Narrating Arab Muslim women's identities in London: Storytelling and the cultural dimensions of the maternity information environment

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Abstract

This thesis describes patterns of cross-cultural communication between Arab Muslim women from Iraq, Morocco and Yemen and London-based GPs, midwives and obstetricians within information-giving encounters in maternity services. It aims to provide a foundation of cultural knowledge on both sets of participants that maternity health professionals may use to inform communication with women from diverse Arab Muslim groups.

A narrative approach to identity is taken in order to explore how both groups of participants position themselves in accounts that were structured around motherhood and the uses of information and oral knowledge on the progress to motherhood. In order to explore the meanings that the physical experiences of pregnancy, birth and motherhood have for women and health professionals, a modified phenomenological approach is taken according to which physical experience is understood to be continually framed by language and by cultural interpretations. Practices of information-giving are explored as these relate to liberal discourses of justice and to the production of a subject to whom rights attach in the public realm. Processes of the legitimisation of knowledge as information are considered as these may be perceived to function to exert power on women's bodies and selves through apparently neutral forms of communication provided by health professionals.

Across Arab Muslim participant groups, perceptions of embodiment, agency and of the uses of maternity information and storytelling diverged along axes of class, nation and locality. Communication with health professionals among each of these groups rested on the manner in which the maternal body was imagined to symbolise belonging to places of origin and on the manner in which experiences of birth in London were used to imagine cultural difference. Findings for health professionals suggested that conflicts in identity arising from the status of the maternal body and of individual agency served to delimit communication with Arab Muslim women and with non-white women in general. Recommendations for health professionals are included in the final chapter.

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Glossary of Arabic Terms

The section in which the terms are introduced is given after the sense used in the thesis.

'āšūrā' : Shi'a festival commemorating the death of Hussayn (1.7.3).

Al-bāri': 'creator' one of the names of Allah (2.4.1).

Ba'ṯ : 'renaissance' Arab Nationalist movement. Split into socialist and fascist branches in Syria and Iraq respectively.

Ĥadīt : the life of the Prophet (1.6.5).

Ĥaram : signifying that which is sacred or forbidden this term also connotes feminine space and has passed into English usage as, 'harem' (1.6.2).

Ĥijāb : covering of a woman's body supposed to have descended from heaven to separate the space occupied by men from that occupied by women (Al-Hassan Golley, 2003) (1.6.2, 1.6.5).

In šā' allah : 'God willing'. A phrase not necessarily indicating particular piety (4.4.1).

Intifāđa : 'uprising,' (1.6.2).

'ird: 'honour,' (1.7.1).

Jamā'at-i-islām-i : 'Muslim assembly'. A Persian term of Arabic origin, denoting a Pakistani organisation active in British Muslim communities(1.6.5).

Qur'ān: sacred book of Islam describing the revelations of the Prophet Mohammed.

Al-xāliq : 'Creator' one of the names of Allah (2.4.1).

Al-muśawwir : fashioner, another of the names of Allah – also contemporary usage - photographer (2.4.1).

Rūĥ : soul (2.4.1).

Śawwara : 'to fashion' or 'form' (2.4.1).

Šarī'a : Divine judgement granted to believers – Islamic law (2.4.1).

Śumūd : 'resistance' (1.7.2).

Tālibān : 'students', used in Iran to signify Islamic students but here denoting Arab-led Islamists who took power in Afghanistan in 1995 (1.6.2).

Umma : global Muslim community also signifying nation or state. Derived from *'umm'* : mother (1.6.4).

Wafd : 'delegation', Egyptian Nationalist part first lead by Saad Zaghloul, that shared power with the King and the British Government during 1920s (1.6.4).

Za'rani : presumably an Egyptian dialect word used to signify lewd stories shared among married women (1.7.2).

Chapter 1:

Transnational Identities: Their construction by Arab Muslim Mothers in Migration

1.1 Introduction

The thesis will describe a study that explores the maternity information-giving encounter as a cultural environment. In order to characterise the cultural dimensions through which the encounter is perceived among groups of Arab Muslim women in London (see 2.2), and among London-based health professionals, a dual focus will be taken. Accordingly, the subject positions adopted by both groups of actors within the information-giving encounter will be considered as these inform transcultural communication in maternity care. Aspects of the diasporic identities of women in the Arab Muslim participant groups will be described through their accounts of the uses they made of maternity information and storytelling during the embodied progress to motherhood[1]. Perceptions of the functions of maternity information and storytelling voiced by London-based maternity health professionals will be explored using the same narrative approach.

The study was conceived as a consequence of previous work on the information needs of Somali women migrants in the UK. This had offered rich areas of exploration surrounding the use of accounts of embodied experiences of infibulation and of obstetric intervention in imagining links to the homeland and in fabling cultural difference in Britain. The study was further moulded by my experiences of living in Syria and of listening to the accounts of friends and their families that described the entry into motherhood. Following from these experiences, within which women presented themselves through their narratives, I took a highly discursive approach to explore the identities of both main participant groups within the information-giving encounter in this study.

The first chapter will seek to outline the theories of identity and language on which the study is founded. Through proposing that identities are constructed in a dialogue between the self and society, it will suggest that these are produced through individual acts of narration. Nonetheless, while language represents a cultural system of interpreting experience, narratives of personal experience may circumvent the cultural schematisation of experience in language. A further source of individual difference in society is suggested to derive from embodied sensation. While the body attests to individual difference in society, embodiment is also intimately related to the social and cultural meanings of the body. As the feminine reproductive body represents the means by which new members enter ethnic and social groups, accounts of maternal and birthing embodiment may serve as a particularly productive means through which to explore the cultural frames within which such experiences are established. Processes of European colonisation have been marked by the creation of systems of representation within which difference and identification were produced through the symbolism of nature and the feminine body. By suggesting that these represent cultural constructions that have served to impose normative categorisations on women and colonised people, the chapter will suggest that embodied sensation may nonetheless present important latitudes for realising individual experience. Conversely, through exploring such accounts, patterns in individual's construction of symbolic bodies may be traced.

In order to characterise the negotiation of individual identity and difference in accounts of communication in maternity services, the study sought to explore the cultural frames of reference used by Arab Muslim participants from three national groups. In this way, while the distinct character of Iraqi, Yemeni and Moroccan homeland societies is emphasised, the study will also be concerned with tracing common elements of homelands that were used by individuals to configure personal cultural identities in migration and settlement. Key factors influencing the creation of subject positions in the homeland and in the Arab and Muslim diaspora will be described in the introductory and in the second chapter. Since many participants had learnt English as adults or spoke through an interpreter, such elements of homeland societies and of transnational belonging were later used to map their individual narrative strategies.

Within the second chapter, the notion of legitimate knowledge will be introduced as a means to understand the cultural dimensions of information-giving and use among both groups of study participants. Constructions of knowledge in Muslim societies and within oral traditions will be explored as narrative and storytelling may be understood to represent legitimate forms

of knowledge that may be legitimated as means to invest lived experience with symbolic meanings for groups of Arab Muslim women. Conversely, maternity information will be explored as a form of legitimate knowledge that may be similarly used to model lived experience around an imagined symbolic body[2]. The chapter will outline studies of the exclusionary basis on which liberal discourses of rights are based and will review studies of health professionals' communication with migrant and Black and minority ethnic women in NHS maternity services. Through these discussions, questions will be formulated regarding health professionals' uses of normative identifications to withdraw from responsibilities to the equitable care of these groups. The third chapter will expand on the relationship between nature and culture in order to describe the means by which a modified phenomenological approach was combined with a narrative understanding of identity. Methods taken to recruit and interview participants and procedures followed to interpret, represent and validate material will also be described. Aspects of the interpretation of accounts will be outlined to illustrate the utility of the approach used. Short biographical sketches of Moroccan, Yemeni and Iraqi participants will be provided in order to establish the differences between these groups. A limited structuralist approach, that will be introduced in the introductory chapter, will be described as it was employed to derive common conceptual oppositions within which identity was articulated within participant groups. The fourth chapter will explore the accounts of Iraqi, Moroccan and Yemeni participants as they serve to articulate individual identity through the uses of legitimate and illegitimate knowledge of the body. By exploring accounts of the construction and uses of legitimate knowledge in relation to notions of class, continuity and of maternal agency, the strategic uses of the maternal body to symbolise both tradition and cultural transgression will be charted. Issues discussed will relate to the construction of 'authentic' ties to the multiple dimensions of the imagined homeland and the diasporic community. Similarly, the fifth chapter will describe the individual means through which institutional, cultural and personal identifications were fabled by health professional participants. Perceptions of displays of individual, willed agency as being prerequisite for the use of maternity information will be explored in relation to accounts the embodiment of Black and minority ethnic women. Similarly, a discussion of perceptions of the appropriate uses of information and of the normative functions of storytelling will trace patterns in the construction of legitimate knowledge. The final chapter will present the findings in relation to the research questions concerning the symbolic status of the maternal body and the uses of knowledge of the body to articulate identity within the information-giving encounter among each participant group. These findings will be combined to characterise the cultural dimensions of transcultural communication in maternity services. Tensions between the symbolic and lived bodies will be considered together with the rich possibilities for

articulating individual hybrid identities that emerged from the accounts of some Arab Muslim groups. A final section will draw on the findings to provide advice to health professionals and to recommend changes in NHS policy. The section will close by describing further areas of research that have emerged from the study findings.

The current chapter is divided into eight parts. The following section (1.2) will describe a theory proposed by Ricoeur, that understands social and personal identity to be configured through acts of narrating experience. This position may be supplemented on a structural level by the work of Lévi-Strauss in order to explore how oppositions within the story line of a narrative may indicate cultural patterns of organising experience. An extension of the notion of a narrative self that may be suggested by the work of Bakhtin, that proposes that representations of the body present possibilities for change in individual and social identity. The third section (1.3), will review understandings of feminine identities that are constructed as being determined by the body rather the mind. Practices of projecting the voices of colonised and formerly colonised groups will be explored as these have been suggested to serve to negatively define European constructions of the responsible subject. Through this discussion, difficulties faced by research that seeks to voice the experiences of groups believed to be silenced will be addressed. The following section (1.4) will outline feminist understandings of the lived experience of feminine and maternal embodiment as the grounds of women's production of cultural identity. Women's individual acts of negotiating with the cultural meanings of the feminine and maternal body will be suggested to be retrievable through their personal accounts of embodiment. Through introducing understandings of transnational migration, the fifth section (1.5), will review multiple dimensions of cultural, economic and social participation in ethnic and national communities that span nation states. This section will also describe how the differentiated model of belonging offered by transnationalism has been used in the associated field of migrant biography to explore how migrants may modify the discourses through which they are perceived through their own life stories. The sixth section (1.6) will explore colonialist and neo-colonialist frameworks of constructing Arab and Muslim women and will consider some functions of representations of Muslim women in western feminist discourses. The section will also review the uses of motherhood ideologies in nationalist, Islamic and Islamist discourses in the Arab world[3]. In order to raise questions concerning the negotiation of representations of motherhood and femininity among various groups of Arab women, the seventh section (1.7), will review recent studies of groups of Palestinian women. Similarities and differences in women's articulation of identities around notions of maternal suffering will also be discussed in relation to discourses of martyrdom among Shi'a Muslim groups and within Christian

Mediterranean societies. The section will propose that, by exploring the maternity stories of individual Arab Muslim study participants, their articulation of individual natural-cultural identities may be traced. Patterns in the recasting of embodied experience within these narratives may point to wider counter-discursive strategies among groups of participants that may reflect the emergence of new identifications in London.

Salient points that have emerged from the discussion will be reviewed in the final section in which aims arising from these points will also be described (1.8).

1.2 Narrative Identity and Embodiment

This section outlines the position on the narrative configuration of identity that will be adopted in the study by exploring the work of Ricoeur. The first sub-section (1.2.1), discusses the relationship of a core identity with a self that is subject to change in time. This sub-section introduces Ricoeur's proposition that personal identity is rendered consistent in time through the individual's acts of narrating personal experiences. Aspects of the structural analysis of myth described by Lévi-Strauss are considered to illustrate the means by which the story line of an account may serve as a metaphor for cultural structures of organising experience. Within the second sub-section (1.2.2), the theory of *hermeneutic phenomenology* that has been proposed by Ricoeur is introduced as this understanding deploys the metaphor of reading and explaining texts to describe the culturally situated nature of personal and social identity. An extension of the narrative formulation of social and self identity considers the body not only as a source of difference but also proposes that the body offers new potentials for identification (1.2.3). According to this understanding, the body, in states of openness or continuity with others in society, represents a powerful means of renegotiating group identities and of affecting social change. Having thus discussed the understanding of narrative identity as this formulation may be modified by the theories of Lévi-Strauss and Bakhtin, approaches that have been taken within the study to narrative, to patterns between narratives, and to embodied identity are described (1.2.4).

1.2.1 The narration of the individual self and cultural identity

Underlying this study is the question of containing difference and of articulating individual and group identities through recounting lived experience. At the centre of this narrative understanding of individual selfhood and social belonging is the conceptualisation of identity in the sense of *'ipse'* and *'idem'*. While '*ipse'* refers to the concept of the self in time, '*idem*' references a conception of an unchanging core of personality (Ricoeur, 1984). In the

exploration of identity, *'idem'*, as sameness, has been privileged over, *'ipse,'* since the latter concept does not conform to notions of an essential self. An understanding of identity in terms of selfhood rather than sameness however may enable the individual's openness to the social and cultural environment to be explored (Ricoeur, 1984).

Having understood knowledge in time to be available only in the form of narrative, Ricoeur perceived that the relationship of the *ipse* and *idem* identities could only be conceived in terms of the organisation of past experience within a plot constructed in the present (Ricoeur, 1984). Similarly, in his conception of *semantic innovation* Ricoeur has described how the imagination can transform experience through the use of metaphor (Ricoeur, 1984). Arguing that metaphor maintains the original meaning of an experience, Ricoeur has suggested that, in giving experience a novel form, the imagination may also enable new associations to be made and potentialities to be known. The use of metaphor thus enables new possibilities to be realised so that the future need not resemble the past (Ricoeur, 1984). Thus having asked who an individual is, Ricoeur concluded that :

'...the identity of this 'who' therefore must be narrative identity' (Time and Narrative III : 246).

By formulating the model of the narrative identity, Ricoeur has provided a means to negotiate out of the impasse of perceiving the self as permanently fixed and also provides a means to refute perceptions of the unified subject as an illusion. These processes of narrating the self in time have also been understood to serve on a societal level where shared cultural narratives are used to legitimate social change (Ricoeur, 1984; see 1.3; 1.7.1). Such processes of the narrative configuration of history were suggested to exercise a formative influence on modes of individual interaction in society as will be discussed below (Ricoeur, 1984; 1.2.2; 1.3; 1.7.1; 2.3).

Having proposed that such shared narratives represent the context in which cultural identity is formed, this understanding appears to share important aspects with the exploration of the structures of myths that has been developed by Lévi-Strauss. As structuralism sought to explore rules for talk in certain fields of communication, using the distinction proposed by Saussure (1916) between *langue* - or the structure of language - and the individual expression used, *parole*, so Lévi-Strauss sought to explore myth through identifying a common set of rules structuring their performance. Lévi-Strauss observed that structures of opposition in the story line of myths remained consistent despite changes to the narrative and

events described. Hence, structures of opposition that were indicated by the events narrated in a myth were understood to represent a form of *langue* - or a set of rules - that determined modes of organising experience within a given group. In his collection of essays, *Structural Anthropology* ([1958], 1963), Lévi-Strauss proposed that myth functions as a system of organising concepts through mediating conflicts in individual and group experience. In this way, in North American trickster myths, accounts of scavenger birds and coyotes that feed on dead animals but do not kill them were understood to serve to resolve the opposition between herbivorous and carnivorous animals. By emphasising the food value of carrion, the interventions of these carrion- eating animals were also proposed to mediate between the opposition of hunting and cultivation by emphasising the common value of these activities in preserving human life (Lévi-Strauss, [1958], 1963). Such structures of binary opposition were proposed to underlie all human culture, all modes of thought and all systems of establishing meaning.

While claims of the universality of systems of organising oppositions are not made within this study, the study findings have suggested a series of latent oppositions across each of the main participant groups. In order to explore these cultural commonalities alongside the examination of strategies of articulating individual identity, belonging and difference, the approach that has been proposed by Ricoeur (above), was supplemented by the insights of Lévi-Strauss with regard to the function of myth as a metaphor for cultural modes of organising experience.

1.2.2 Cultural interpretations and re-imagining of the self

Through his formulation of *hermeneutic phenomenology*, Ricoeur described a model of reading that offers wide latitudes for the negotiation of cultural and social belonging through memory and imagination. Having understood the individual to access ways of interpreting experience through an act analogous to reading a text, Ricoeur proposed that the meaning of the 'text' was available through the cultural medium of language. Conversely, the possibilities for being that were understood to be offered by a text were suggested to be meaningful only insofar as they resonated with previous experience. In this way, while possibilities for being in the present were understood to be given meaning through language, memories of previous experience were suggested to provide critical distance for the individual who drew upon personal experience to situate concepts and relations that might appear to be fixed by language (Ricoeur, 1973). Hence, in the metaphorical act of reading that represented the interaction with culture for Ricoeur, the tension between the reader and

the cultural interpretations within which the text was structured, was never finally resolved (Ricoeur, 1988). Rather, the cultural system of language and individual experience were perceived to negotiate within an, 'open-ended, incomplete,' relationship that enabled new identities to emerge (Ricoeur, 1988: 207). Nonetheless, despite the impossibility of attaining a final, consistent self, the negotiation between self and culture that was understood to occur through the metaphor of reading was not perceived to defer meaning, but to support positional identities that were made consistent through the process of narrating experience. Hence, language for Ricoeur, particularly in its symbolic, metaphoric and fictional forms represented the site where consistent individual selves were understood to be produced and where cultural identity was negotiated.

1.2.3 Interaction and writing embodied difference

While Ricoeur's understanding of the narrative self rested on an internal dialogue between the self and the cultural system of language, in his theory of dialogic identity, Bakhtin appears to have entirely abandoned the idea of the self-contained individual. Taking the boundaries of the embodied self to represent the active site of dialogue with other individuals, Bakhtin understood personal identity to be a joint production of interlocutors (Bakhtin, [1979], 1986)[4].

Within the understanding of *hermeneutic phenomenology,* the lived body or, 'flesh,' was understood to represent a source of difference to the *idem* self (Ricoeur, [1990], 1992: 318). Having been perceived to serve as a mediator between the self and the world, the lived body – that was viewed as different to the *idem* – was understood to enable others to be established as different from the self (Ricoeur, [1990], 1992). For Bakhtin however, the self was seen as being formed through the difference represented by the bodies of others. Through confronting the discontinuity between personal embodiment and the bodies of others, the difference that enabled the self to be realised in dialogue was perceived to be established (Bakhtin, 1986). Having suggested that bodily transgression symbolises the inversion of social hierarchy and the suspension of laws and social norms in his theory of *Carnival*, Bakhtin proposed that the body may serve on a cultural level to symbolise potentials for social change (Bakhtin, [1965], 1984; see 1.3.3). Hence, where Ricoeur celebrated the transformative power of metaphor, emplotment and acts of reading as means to engage with culture and to establish a self in time, Bakhtin established physical transformation as the site through which new social and personal identifications emerged. Writing the experience of the transgressed body into language was understood both to realise these potentials and to release them into collective social life (Bakhtin, [1965], 1984).

1.2.4 Approaches to narrative identity and embodiment taken

As the meaning of experience has been understood by Ricoeur to be established in language, it is proposed that participant narratives be explored from the perspective of narrative strategies undertaken to fable individual embodiment (see 3.4; 6.1). In this way, by following the thread of individual narratives in English or Arabic, the personal identities and social positions of participants will be traced. Similarly, as 'myths' have been understood by Lévi-Strauss to function as cultural systems of organising experience, where the treatment of oppositions across accounts of shared experience is explored according to a structuralist approach, recurring strategies of representation used by participants may be characterised as cultural. Since Bakhtin has proposed that introducing the difference represented by the body into the dialogue between the self and other individuals has the potential for social change and individual transformation, the treatment of individual embodied experience in participant narratives may de-stabilise cultural systems of representing the body and of legitimating knowledge as it may also re-inscribe its belonging to new cultural identifications.

1.3 Ethnic Identity, Boundaries and Dangers

This section introduces a theorisation of ethnic identity that understands such identities to be negotiated through the actions of individuals at the boundary with ethnic difference. The first sub-section (1.3.1), describes a model of ethnic belonging that explores the interaction of individuals with ethnic others as the foundation of group identity. The second sub-section (1.3.2), explores the construction of colonial identities through the projection of selected characteristics onto colonised groups that come to represent (inferior) difference. Such identities that have been constructed to represent the inverse of European models of the self are suggested to have served to invite colonial intervention and exploitation and to legitimate colonial systems of oppression. Within the final sub-section (1.3.3), the symbolism of the body will be considered as this may reflect dangers to the ethnic group. As feminine identities have tended to be perceived to be marginal to group identities, the section will also consider how feminine reproductive bodies may come to represent the boundaries of the group. By virtue of their position at the interface with ethnic difference, women's reproductive bodies may thus represent a source of danger to cultural integrity.

1.3.1 Personal agency and cultural norms in the negotiation with difference

The understanding of the interactive basis of the construction of self proposed by Bakhtin, and that of the negotiation of the self between individual experience and cultural, 'texts', proposed by Ricoeur (1.2), relates closely to the work of Barth on ethnic groups. Having proposed that ethnic identities are not fixed, Barth developed a model of ethnic identity that envisaged such identification to be continually subject to negotiation by individuals in the ebb and flow of political currents (Barth, 1969). Central to this position, is the assertion that, to be useful to the members of a collectivity, collective identities need to be accepted by other collectivities, who give them signification and currency (Barth, 1969). Consequently, identification has been suggested to be produced at the boundary of the collectivity with other groups that offer their interpretations of it. Having located the production of ethnic identity at the boundary with difference, this theorisation of social processes may be used to understand the extent to which decisions made by individuals determine or transgress group boundaries. Accordingly, the project envisaged by Barth sought to:

'.. .explore the extent to which patterns of social form can be explained if we assume that they are the cumulative result of people acting vis-à-vis one another... patterns are generated through processes of interaction and in their form reflect the constraints and incentives under which people act'. (Barth 1969, p. 2. Cited in Jenkins, 1996, p. 91)

Having observed the social life of the Pathans of Swat in North West Pakistan, Barth noted how political groupings grew out of personal interactions and were negotiated through these (Barth, 1959)[5]. Having taken his position further, Barth also questioned the assumption of the persistence of differences between ethnic groups. Nonetheless, he suggested that boundaries between ethnic groups persisted despite the changing membership of groups through the migration of individuals to other groups (Barth, 1969). As ethnic identities have been understood to be generated through acts of personal agency in interaction with the members of other groups, such identities may also be understood to have an existence outside individual lives. Accordingly, in order for an individual to remain inside a given group, such individual acts of interaction – while potentially modifying the relations of the group to ethnic and cultural difference - must also correspond to wider cultural norms. Practices of the use of Muslim tradition among Muslim migrant women to advance claims to greater participation within the community and to signal new identifications in migration may be seen to reflect a similar model of the negotiation of group identity (1.6.5).

1.3.2 Ethnic and gender difference and the colonial construction of commonality

An analysis of the defining functions of ethnic difference among colonising people and among the colonised has been offered by post-colonial studies. Additionally, having recognised the function of difference exterior to the group in establishing commonality within it, post-colonial histories have explored the representative processes that construct difference. Disparities in political power between colonising and colonising groups, have been suggested to be mirrored in the disproportionate authority of the colonising culture (Fanon, [1952], 1967). More specifically, political imbalances on which the colonial project was based, have been suggested to feed into representative systems that produce and project difference onto the colonised group (Fanon, [1952], 1967). Of particular interest in demonstrating the fundamental role played by representations of the colonised group in constructing racial hierarchies are practices in European literature of imaginatively investing black men with animal characteristics (Fanon, [1952], 1967). Where such representative strategies related to Black women during the period of slavery, their imaginative reduction to an animal status appears to have served to justify the commodification of their reproductive capacities (Bush, 2000).

Additionally, by denying the efforts of colonised people – particularly those of women and the less-educated – to represent themselves, native societies were re-presented as being ossified and inhumane (Spivak, 1999). Representations of these relatively powerless groups – termed subaltern – thus corroborated European studies of native élites in order to produce accounts of the colony in which the European coloniser adopted the role of the educator and liberator of subaltern groups (Spivak, 1999; see 1.6). The initial period of European colonial conquest coincided with the gradual adoption, in European colonising states, of understandings of the agency of free individuals as a basis for participation in these societies (2.3). In order to preserve the rationale for colonialism, identifications that were considered to represent the inverse of the free European agent were projected onto the bodies of colonised men and women. Representations of colonial others such as the unselfconscious New Hollander referred to by Kant in his *Critique of Judgement* thus served crucial functions in constructing European (male) selves around notions of culture and self-knowledge (Spivak, 1999: 26 – 33). Analogous processes of conceiving a western feminist self through conceptions of individual agency will be considered below as they may serve to replicate colonial representative strategies of opposing the native to European civilisation (1.6). The construction of the subaltern as a category whose subject positions are adopted in western rhetoric raises compelling questions for cultural research that seeks to voice the concerns of groups who do not have access to public discourses. Nonetheless where the legacies of such

systems of representation have been recognised and where material records exist, histories of previously silenced colonised subjects appear to have been successfully traced (Spivak, 1999). Following this precept, the study will outline cultural systems of representing Arab Muslim women before embarking on an interpretation of their narratives.

Identifications with the body, divergent sexuality, irrationality, femininity and decay within which colonised identities were imagined may be termed *abject,* using a limited application of the term originally used to connote qualities that need to be both excluded and rejected in order to enter into culture (Kristeva, 1982). A central characteristic of *abjection* as it was originally used and it will be deployed here relates to its effect of excluding from power those represented as being in its possession (Kristeva, 1982). Through the construction of the colonised (male) subject within such *abject* categories, he was thus demonstrated to be incapable of developing a sense of responsibility and was thus also permanently disabled from exercising freedom and rights within the law (2.3.3). Conversely, strategies of the construction of *subaltern* subjects through *abject* identifications, have also been suggested to serve as the repository of the desires that underlie colonising cultures. In this way, colonial strategies of representation have been suggested to be intrinsically connected with colonising societies and with the neo-colonial societies that developed from them (Spivak, 1999). Such continuing effects of colonialism will be explored below in the discussion of Arab and Muslim women's constructions of identity in the Arab and Muslim world and in migration (1.6.1 – 1.6.5). The legacies of these systems of representing Muslim women will also be traced within contemporary western feminism (1.6.2). Similarly, parallels between the representative systems that constructed the bodies of women in European and non-European societies are considered below as they relate to perceptions of the margins of the social structure of western societies (1.3.3; 1.4).

1.3.3 Bodily Boundaries, Dangers and Ethnic Identity.

In common with Lévi-Strauss, Douglas has argued that culture represents a system of ordering experience (see 1.2). Douglas however, understood the margins of concepts to represent a danger to group identity as they challenge its cultural system of ordering experience. As such, states of transition between cultural roles - and individuals that cannot be clearly placed within cultural systems - were understood to represent sources of potential harm (Douglas, [1966], 2004). Douglas further proposed that bodily boundaries had a privileged function in organising cultural identity (Douglas, [1966], 2004). Accordingly, Douglas proposed that the ritual treatment of bodily boundaries reflected the particular risks

and problems encountered by a given group. The boundaries of the body – and particularly its openings – were thus understood to represent the margins of the group and the means of incursion into it.

In this respect, the understanding of the symbolic functions of the body that was described by Douglas has similarities to that suggested in Bakhtin's formulation of *Carnival* (1.2). In contrast to the emphasis that Bakhtin placed on the representation of the inversion of the social order (1.4.2), Douglas examined the behaviours of groups in seeking to contain the symbolic potentials of open bodies. An example that Douglas provided to support this understanding relates to beliefs among the Coorg group, for whom any matter expelled from the body must never be readmitted. Douglas proposed that this model extended to the entirety of the Indian caste system in which lower castes represent the source of symbolic contamination to higher castes through their contact with the products of bodily margins (faeces and blood) and with corpses (Douglas, [1966], 2004). However, she also related the particularly rigorous rituals of the Coorg group to their isolation and minority status (Douglas, [1966], 2004). In this way, the ritual protection of entries into the bodies of individuals has been said to enact a symbolic resistance to external pressures.

Douglas illustrated how processes that transgress the body may be seen as being in need of particular protection from the 'danger' represented by ethnic and cultural difference. Within the Hindu caste system as a whole, membership of a caste is transmitted by the mother (Douglas, [1966], 2004). Accordingly, the transgression of the group boundary may become symbolised by the sexual behaviour of women (Douglas, [1966], 2004). Douglas thus understood punishments for sexual contact with members of lower castes that were inflicted on higher-caste women in terms of the perception of the act of heterosexual intercourse as a form of symbolic incursion into the group (Douglas, [1966], 2004). Within Arab Muslim societies, where descent is not usually matrilineal, family and group identity may also rest largely on female sexual behaviour (1.6). As such, the symbolic values with which the orifices of the female body are invested in birth and reproduction may also reflect dangers of incursion into group identity and may become the focus of practices of identification among women (1.6). In addition, concerns relating to the maintenance of group identities in migration may also come to condition meanings ascribed to embodied experience (6.2; 6.3; 6.6; 6.7).

1.4 Feminine Embodiment and Maternal Selves

This section will review studies of the status of feminine and maternal bodies that suggest that symbolic representations of these bodies have served to delimit the scope for articulating individual feminine selves. Within the first sub-section, an overview of similarities between the projects of post-colonialism and feminism describes systems of representation through which women and colonised people have been denied the status of full subjects. The second sub-section (1.4.2), will consider the symbolic representation of the feminine body within western societies and will explore divergent approaches taken to configure resistant feminine identities. Within the third sub-section (1.4.3), divergent approaches taken to understand such practices of resistance will be reviewed. The final sub-section (1.4.4), will describe models of femininity that draw on a phenomenological understanding of the lived body as being experienced through its location in a web of natural-cultural relations. The section suggests that individual feminine agency may be reclaimed through exploring of the specificity of women's embodied and cultural experience in relation to wider cultural constructions of the symbolic maternal body.

1.4.1 Dualism and the status of feminine selves

As has been the case in the writing of post-colonial histories, the redemption of women's selves from cultural strategies of representation has formed the core of the feminist project. The articulation of individual female identities among women from formerly colonising nations, as for those from formerly colonised groups, has been complicated by the cultural meanings with which the female body has been invested within western societies. Having been cast as the body within the Cartesian binary opposition, representations of occidental and oriental or colonised women have served to support understandings of the rational (male) subject. In this way, through processes of projecting onto women highly selective experiences of feminine embodiment, the articulation of individual feminine selves remains delimited by normative identifications with essential and universal femininity.

1.4.2 The female body and normative categories of femininity

While outlining constructions of the feminine body as the repository of male imaginings, much work on occidental discourses of femininity has nonetheless appeared to accept the reduction of feminine selves to categories deriving from normative understandings of female bodies. In attempting to forge a path out of the 'prison' of identifications with gestation and generation, the position may have been described most forcefully by de Beauvoir ([1944],

1997: 35). By tracing representations of the female body as 'other' to discourses of the rational individual subject, de Beauvoir critiqued the construction of femininity as a normative category (2.3.2). Hence, she maintained:

'A man is in the right in being a man; it is the woman who is in the wrong. It amounts to this: just as for the ancients there was an absolute vertical with reference to which the oblique was, so there is an absolute human type, the masculine. Woman has ovaries, a uterus; these peculiarities imprison her in her subjectivity; circumscribe her within the limits of her own nature' ([1944], 1997, p. 16).

Since these assumptions were perceived to serve to delimit feminine willed agency, de Beauvoir proposed that the feminist project should seek to reconfigure feminine identifications around individual, willed agency. However, having taken essential and universal conceptions of women to represent an unassailable cultural reality, she appears to have argued that it is the biological basis of gender in sexual difference that consigns feminine identities to this identical and essential status. In this way, while she characterised the cultural structures that reproduce gendered alterity, de Beauvoir deduced that no fundamental feminine identity existed but that projected onto women as the inverse of (masculine) reason. Having been understood solely through normalising representations of women, de Beauvoir thus reduced femininity to a set of habitudes produced by 'culture' and learnt by women:

'... one is not born, but rather becomes, a woman' ([1944], 1997, p. 295).

In seeking to grant women intellectual agency, de Beauvoir proposed that femininity should be understood to represent a cultural construction. In contrast, Irigiray ([1984], 1993), maintained that such an understanding of feminine selves would function to elide embodied experiences and would do so within an invigorated universal ideal of, (masculine) reason. Nonetheless, despite appearing to seek to remove women's selves from their experiences of sexual difference, the conception of gender as a set of cultural practices that was proposed by de Beauvoir, formed the basis for an important reconsideration of the status of the female body in constructing individual feminine selves.

In contrast, an approach that took the embodiment of women and the capacities of the feminine body for pleasure (*jouissance*) as the grounds of feminine difference was elaborated in the formulation of *écriture féminine* (women's writing). Texts describing experiences of

sensory multiplicity as an essentially feminine ontology were suggested to serve to undermine processes of ascribing fixed meanings to concepts, words and objects. By destabilising fixed cultural relationships of meaning between words and their sense, the introduction of feminine embodiment into texts was suggested to present new possibilities for women's identifications (Irigiray, [1984], 1993; Kristeva, 1980). Through its focus on bodily experience as a means of circumventing culturally determined meanings, the theorisation of *écriture feminine* may be seen to be analogous to that of *hermeneutic phenomenology* in which the self has been envisaged to obtain individual identity through bringing personal experience to bear on cultural, 'texts' (1.2). Similarly, through identifying the disruptive potential of cultural reproductions of embodied openness – particularly as these relate to birth and eating – the practice is consonant with the work of Bakhtin on the functions of accounts of the transgressed body (1.2). Nonetheless, the formulation of the transgressed body proposed by Bakhtin has been imagined as an integral part of the regulation of early modern society (Eagleton, 1987). As such, the difference represented by the transgressed body would appear to entail meanings that remain unfixed and that, hence, remain politically indeterminate. Similarly, in proposing the writing of embodied feminine multiplicity and *jouissance,* the practice of *écriture féminine* appears to have conflated individual experience with normative categories of femininity. Hence, by recourse to a universal conception of feminine sexuality or sensuality, the practice functions to obscure feminine experience by eliding individual difference and personal agency (Guillaurin, 1979). A further charge against the practice is that it appears to envisage sensual experience to exist outside – and prior to – culture (Butler, 1999).

1.4.3 Feminine Discipline, Cultural constructivism and the mind-body binary

While a consensus has been established among feminist theorists around the understanding of the feminine body as a cultural text, for many it has remained too culturally inscribed to be safely explored without appealing to notions of a pre-cultural feminine essence (Heckman, 1999). Questions concerning the status of the body and the role of feminine willed agency in articulating women's identities have been illustrated by developments in the work of two major theorists. The work of Bordo has explored the embodied experience of female *disciplines* of diet and exercise as practices performed on the body that seek to assert the location of feminine identifications in the rational will (Bordo, 1987; 1990; 1993). In apparent contrast, Butler has focused on historical representations of female bodies that produce sexual difference as an ideal that serves to regulate identifications and practices (Butler, 1990; 1999).

As such, while Butler has not disputed the material existence of the female body, she has suggested that sexual difference is experienced as an effect of cultural representations of the body (Butler, 1999). Since Butler understood the continual reiteration of this process of demarcating, circulating and differentiating representations of bodies to be necessary to 'force' the materialisation of sexual difference, she also perceived that the construction of sexual difference was, 'never quite complete' (Butler, 1999: 236). As such, she has explored the subversive possibilities of parody in destabilising the representative system that produces sexual identity (Butler, 1990). Nonetheless, having shadowed many of the contradictions inherent in Bakhtin's understanding of *Carnival* and in the formulation of *écriture féminine*, the model of resistance proposed by Butler may serve in practice to regulate and delimit the transgressions it seeks to support (Marshall, 1990). Thus, by exploring the operation of regulatory sexual norms on a cultural level only, the formulation of *masquerade* proposed by Butler can offer no challenges to women's lived experiences of resistance or oppression (Marshall, 1999).

As Butler has maintained that sites of resistance to normative categories of femininity are created by those same practices, so Bordo has also denied any appeal to a female body outside its cultural and linguistic construction. Rather, by exploring the dietary *disciplines* and exercise regimes of anorexic and bulimic women, Bordo has been able to magnify aspects of the erasure of the embodied self that are undertaken by women who seek to assimilate to an exaggerated model of normative femininity (see 5.2). As such, by focusing on the particularities of the experience of individual women as they seek to reproduce a normative identification, such studies may also enable the cultural system that produces these to be characterised (Hekman, 1998).

1.4.4 Phenomenology and the natural-cultural body

Through its recognition of the body's creative engagement with the world, phenomenology focuses on the particularities of the lived body as the basis for forming personal and social identity (1.2). Questions of cultural status of the body in phenomenology have remained largely undetermined and as such, the relationship of embodiment and culture, that might appear to offer itself to phenomenological methods, has remained outside the scope of much phenomenological work. Nonetheless, feminist theorists have critiqued and adapted the non-dualistic understanding of embodied identity developed in the work of Merleau-Ponty to provide a model through which to explore women's individual negotiations with both nature and culture in their accounts of embodiment.

Early phenomenology, represented by the work of Husserl (1913), has been critiqued by Ricoeur for its basis in empirical assumptions concerning the pre-cultural nature of sensory experience (Ricoeur, 1975). Similarly, the problematic relationship of language and embodied experience in the work of Merleau-Ponty, must be carefully explored in order to realise the potential of his understanding of the cultural context in which embodiment is experienced. In his major early work on perception, Merleau-Ponty ([1945], 1996) sought to step outside the body-mind dichotomy. Accordingly, in place of the polarities of body and mind, he proposed that the body is a sentience that is continually brought into being in a particular existential context. The emphasis on the primacy of learnt behaviour over reflection in his early work may have indicated that embodiment might be understood to exist outside a cultural context. Nonetheless, in his last, unfinished work, Merleau-Ponty critiqued his own previous emphasis on the pre-reflexive character of embodied sentience (Merleau-Ponty, [1964], 1968). In the same work ([1964], 1968), Merleau-Ponty also critiqued the wider phenomenological project of Husserl that envisaged exploring the *essences* of individual experiences of objects, relations and people in the world. In contrast, he maintained that the identification of the essence of an experience was impossible given that embodied experience was given meaning through language – and hence was understood to have its being in a cultural context (Merleau-Ponty, [1964], 1968).

The distinction between the early and later attributes that Merleau-Ponty attached to embodiment, may be largely a product of the author's self-criticism. In his earlier work, the context in which embodied consciousness exists, was not understood to consist of fully determinate objects, nor was it understood to exist wholly outside the body (Merleau-Ponty, [1945], 1996). Rather, having proposed that, 'man is but a network of relations,' Merleau-Ponty understood the self to have its being within its relations to the environment, objects, people and projects (Merleau-Ponty, [1945], 1996: 530). By adopting this understanding of the mutual encroachment of relations of belonging to the world and the experiences of the lived body, Bigwood has developed a model of a natural-cultural body through which lived experience was established within language (Bigwood, 1999). Through this model, individual accounts of embodiment may be reconciled with the wider symbolic construction of the body.

Accordingly, Merleau-Ponty's understanding of language as the basic condition for realising lived experience, provides an excellent basis to explore the relationship of individual sensory experiences to symbolic bodies through participants' accounts of maternity experiences and the uses of knowledge to understand their changing states. In this way, participants'

embodied selves were understood to be narrated in relation to a symbolic body and in relation to cultural difference. Both conceptions of embodiment and of the symbolic body were understood to be located in a web of natural- cultural relations.

Given the indefinite and multiple nature of individuals' relations with the world that were described throughout the work of Merleau-Ponty, women's experiences of gender cannot be divorced from the wider the sensory and cultural conditions in which their embodied selves are produced (Bordo, 1990). However, a second critique of the phenomenological body described by Merleau-Ponty focused on its claims to gendered indeterminacy. Having noted that the phenomenological body explored by Merleau-Ponty was male (it was his own), Grosz contrasted the construction of the masculine body that she understood to represent the apparatus of willed agency to that of the female body, which she has understood as having been culturally constructed to exist in a natural state (Grosz, 1994). Having suggested that identifications with nature represented a primary context for women's identifications, Grosz confounded an awareness of the culturally constructed nature of women's experience with the pursuit of an essence of femininity. Nonetheless, by inserting the female body with its culturally reinforced material specificity into the notion of the lived body, she nonetheless created a powerful – if not unambiguous – means to explore the degree to which women's embodiment is culturally implicated.

For women in western societies, exploring the embodied experiences of the lived body has offered rich possibilities for identifying cultural structures of oppression. Accounts of embodiment have thus offered an important medium in which to formulate identities that resist normative constructions of the symbolic feminine body. The saliency of the mind-body binary in producing and projecting *abject* identifications onto Black and minority ethnic women may be particularly marked where women from these groups migrate to formerly colonial states. As such, the exploration of the use of symbolic maternal bodies within accounts of the natural-cultural experiences of pregnancy and birth among these group would appear to represent a fertile field of inquiry for Black and minority ethnic migrant women and for feminist theory as a whole.

1.5 Transnationalism

This section describes approaches to understanding international migration that explore ways in which the individual autobiographies of migrants and the actions of migrant groups serve to establish new identities in the country of settlement. The first sub-section (1.5.1), provides an overview of, transnationalism as an approach to migration studies that focuses on the relationships between the migrant community, the 'homeland' and the wider diaspora group. It describes how work using this approach has examined how individuals expand the terms in which they identify following their acts of migration and their continued involvement in the homeland and the migrant community. The second sub-section (1.5.2), explores the cultural uses of women's bodies and behaviours as they are invoked as tokens of difference and belonging. Within this sub-section, a study of the use of motherhood discourses among a British Muslim women's group serves to suggest how strategies of producing symbols of authentic belonging may also provide discursive spaces through which women may successfully lever authority within the migrant group and within wider political contexts. In accordance with the understanding of the narrative configuration of the self (1.2), the final sub-section (1.5.3), discusses a study of the life-history of a Turkish migrant woman in Germany.

1.5.1 Overview

An approach to migration studies that has developed since the 1990s and that attempts to understand the flow of migrants and the accompanying, homeward flows of information, money and cultural reproductions, is that of transnationalism. While researchers on migration have generally acknowledged that migrants maintain ties with people and organisations in the homeland, particularly through remittances and correspondence, the majority of migration research since the 1920s has explored factors influencing adaptation to - or exclusion from - the host society (Vertovec, 2001). In contrast, transnationalist work has considered the cross-currents of these cultural and material goods in terms of realignments in the international configuration of power and capital and in terms of transformations in political economy which require increasingly mobile workers (Vertovec, 1999). However, perhaps the most innovative focus of transnationalism is the study of the construction of individual and group identifications across national boundaries and their potentials for problematicising and expanding existing categories of ethnic and gender identification (Anderson, 2001; Pesser and Mahler, 2001).

1.5.2 Cultural authenticity and transnational belonging

Many individuals and groups in diaspora continue to be politically and materially implicated in nationalist projects in their homeland (Østergaard-Nielsen, 2001). Conversely diasporic identifications may also evolve within political and historical currents in the country of migration or settlement. In order to resist what is often perceived as the corroding cultural influences of the host society, many diaspora groups have sought to invoke discourses of cultural authenticity in which the bodies and behaviours of women come to represent signifiers of cultural difference to the host society (Anthias, 1998; Gopinath, 1995; see 1.3). As migrant strategies of defining and producing symbols of cultural belonging seek to project normative representations of femininity onto women, so the discursive process of establishing such symbols may also provide resources that may be called upon by women to enlarge the discursive space within which their identities are articulated. .

Werbner (2002), has explored the emancipatory political potential of transnational identifications through the philanthropic activities and political organisation of Muslim women in Manchester during the mid-1990s. The women's organisation, *Al Masoom*, was formed to raise funds for a cancer hospital for children in Pakistan but widened its activities to collecting dowries for poor Pakistani brides and to campaigning against human rights abuses suffered by Bosnian Muslim women. As a result of these activities, including dangerous overland missions to Bosnia, the women were reported to have gained an important place in the British ethnic political arena and within the South Asian communities of Manchester. To a lesser extent the group also established a presence within the larger Muslim umma[6] (global community of believers). Having focused on providing care and support to other Muslim women, the group legitimated its actions in the public sphere by recourse to the multiple identities of its members: as mothers, as ethnic Pakistanis (or Pakistani minorities) and as Muslim women who were British citizens. Within each of these context, the members of *Al Masoom* were suggested to have used and expanded the cultural typologies of feminine reproductive and nurturing functions. The account illustrates how women in diaspora may use the liminal space they occupy with regard the host society and with regard to discourses of authority within the ethnic and cultural groups to which they belong, to establish culturally legitimate routes into the public sphere. More widely, through pursuing political activities, the members of *Al Masoom* may also be seen to have redefined the terms of their cultural belonging to the migrant community and their relations to the host society (Werbner, 2002).

1.5.3 Migrant Autobiography

As Ricoeur and Merleau-Ponty understood embodied experience to be realised through the narrative configuration of a continuous self, so the homeland or the family homeland also represent ideas that are realised through their imaginative retelling. The imaginatively constructed character of the homeland has been described by Hall (1990), for whom it was always geographically elusive so that a physical homecoming was never possible. Rather the homeland represented:

'... something that has to be told. It is narrated. It is grasped through desire. It is grasped through reconstruction... What emerges from this is nothing like an uncomplicated... past' (Hall, 1991, p. 401).

Through narrating the past, both in the homeland and after migration migrants may themselves mediate and contest the experience of ethnicity that was reconfigured or imposed in the country of settlement. Such acts of autobiography may provide migrants with a terrain for re-invention and may be particularly salient when conditions that would normally inform self-identity become unstable (Ganguly and Taras, 1998).

Inowlocki and Lutz, (2000), described how the narrative strategies of a Turkish immigrant woman in Germany enabled her to reclaim events in her life history. Having suggested that the woman's account enabled her to negotiate with representations of Muslim immigrant women in terms of being an, 'uncivilized [sic] stranger', in terms of the discourse of honour and in terms of being 'twice rootless', the authors traced the narrative strategies through which she defined a discursive space for herself (Inowlocki and Lutz, 2000: 307). One of the most significant events that the woman recounted was a medical examination that she underwent in order to obtain permission to work in Germany. While many of the her accounts were paraphrased, this was quoted at length by the authors. Accordingly, the woman explained how before this examination, potential recruits were segregated by gender and asked to strip. Women who covered their breasts with their hands, in accordance with Turkish social norms, were subjected to the ridicule of the German medical personnel (Inowlocki and Lutz, 2000: 308). The women's urine and blood was tested and the alignment of their spines and their teeth was checked. Their breasts and genitals were also checked. Having described these procedures, the woman continued to explain how applicants were required to hold their hands straight ahead to identify propensities for nervous tension. As the two parts of the life-history - pre- and post migration - appear to have hinged on this event, the examination may also have represented the participant's imminent change in status, from

Turkish peasant to a guest worker in Germany. The woman suggested that the procedures served to objectify her having explained that: 'you're just a number', and commented that 'we were being treated in an inhumane way'(Inowlocki and Lutz, 2000: 308). However, she continued immediately to reflect that, 'Of course, we were all perfectly healthy, the people who passed' (Inowlocki and Lutz, 2000: 308). Accordingly, the authors emphasised how, through changing her perspective from her embodied experience to an objective view of the event, she refused to adopt the position of a victim. By the same means, the authors also suggested that she created a reciprocal relationship with the researchers who interviewed her, thus re-claiming the loss of personal agency in the event she recalled. The procedures of objectification imposed upon her body, that may also have served to suggest disjunctures in her identity, thus appear to have been resolved within the account through which she claimed her personal agency in this event that led to her migration (3.3.2).

1.6 Discourses of motherhood and femininity in the Arab World

This section outlines colonialist and neo-colonialist constructions of feminine identity in the Arab and Muslim world and suggests patterns through which Islamic and Islamist motherhood ideologies reflect and diverge from these representations. The first sub-section (1.6.1), provides the rationale for considering motherhood as an important nexus of identity for Arab Muslim women by suggesting that for Arab Muslim women, motherhood represents a site on which cultural constructions and embodied experience converge. Within the second sub-section (1.6.2), the legacy of colonialist constructions of Muslim societies is considered in relation to the construction of Islamism as a discourse of radical difference to European and Anglo-American societies. The third sub-section (1.6.3), describes various discourses surrounding motherhood in Islamist groups and societies. The sub-section describes practices of valorising maternal responsibilities that oppose motherhood to responsibilities in public life. The final sub-section (1.6.4), considers the functions of constructions of femininity in configuring representations of national unity. The deployment of constructions of autonomous women within Arab nationalist discourses are also considered. Finally, more recent studies examining the repeal of representations of women's political participation in liberation struggles, are also discussed in relation to the use of traditionalist family structures to contain difference within national communities that are profoundly divided along axes of social, ethnic and regional belonging.

1.6.1 Motherhood as a social construct in the Arab World

Motherhood has been chosen as the focus of this study due to the ways it is powerfully represented as being contiguous with femininity in the Arab nationalist discourses described below and in the beliefs and practices of vernacular Islam. In addition, as will be described, ideological representations of Muslim mothers have been commonly deployed in the discourse of oriental inferiority and subsequently in Islamism and in international Islam. Nonetheless, while motherhood represents a significant episode in most women's lives and it is assumed that maternity narratives will play a part in Arab Muslim women's self-representations in London, this study has made no a priori assumption regarding the meanings of motherhood for individual Arab Muslim women. Indeed, for many women in the Arab world who are already mothers, the birth of further children may be a highly unwelcome event and may represent a threat to the wellbeing and economic survival of the woman and her family. The widespread nature of these experiences would appear to be attested by the large number of legal abortions in Egypt and Tunisia that are carried out when the woman has already completed her family (el-Saadawi, 1980). Furthermore, economic pressures in other Arab countries may lead to unknown numbers of illegal abortions. These practices are likely to be relatively common among poorer, working women (el-Saadawi, 1980).

The study therefore considers motherhood to be a social and ideological construct with which Arab Muslim women negotiate and through which they represent themselves. At the same time, pregnancy and birth are understood to be experienced as embodied processes that may also involve important ontological shifts (Young, 1990). Among women in diaspora in former colonising states, motherhood may be imbued not only with gender-specific myths but may also be moulded by conceptions of ethnicity, femininity and difference. Given the dialectic nature of culture and identity described above (1.3), the ways in which motherhood is configured among groups of Arab Muslim women in London will be explored in terms of the narration of embodied experience at the interface with cultural difference (1.2; 1.3; 1.4).

1.6.2 Neo-colonialism and Muslim women as signifiers of difference

Different experiences of colonialism in the Middle East and North Africa have led to divergent constructions of Arab identities as the position of Islam in emerging nationalist identities was partly obscured by the experience of Muslim colonialism in the former possessions of the Ottoman empire (Arkoun, 1994; Al-Azmeh, 1993)[7]. However, since the Syrian-Egyptian defeat of 1967, and more recently through the continuation of the second intifāda (uprising) and the occupation of Iraq, commentators have noted that Arab identity

has become increasingly configured around Islam and Islamism (Chomsky, 2001; Vertovec, 2000).

The effects of colonialism - in the form of Orientalism – have been suggested to continue with profoundly disruptive effects on the construction of Muslim and Islamist identities. As the properties of Islam were constituted in Orientalist discourse in opposition to rationalist values claimed by western societies (Said, 1979; see 1.3), Islam became represented as a category consisting of fanaticism, exoticism and traditionalism that was used to define and delimit the articulation of individual Muslim identities (Al-Azmeh, 1993). These practices of projecting universal difference onto Islam have been suggested to have their legacy in much contemporary western scholarship, in which religious, sectarian and ethnic affiliations within the Muslim world are reduced to identities definitively constituted outside historical conditions (Al-Azmeh, 1993). Entailed in this process are beliefs that Muslim identity is impermeable (Al-Azmeh, 1993). Accordingly, relations with western states are assumed to be ones of irreducible difference that will lead inevitably to actual conflict (Al-Azmeh, 1993; Said, 1981). Al-Azmeh (1993), also described how the Islamist notion of a return to an essential Islam has grown out of similar strategies of representation. Having substituted a narrative of the corruption of Islam by European states for the complex histories of Muslim societies, Islamist discourses have also promised to re-enact an Islamic utopia in which a harmonious social order is imagined to emerge, 'vitally' from Islamic doctrine (Al-Azmeh, 1993: 65). Having sought to remove Muslim societies from their historical conditions and by defining Islam primarily in opposition to occidental democracies, Islamist discourses have thus functioned to reverse the terms of colonialist representations but have left the structure of essential difference intact. Hence, Islamism has served to invigorate perceptions of the antagonistic nature of Islam within occidental democracies while also feeding into discourses of segregation among Muslims.

Islamist constructions of the domestic woman and measures to impose these constructions within the Arab world are also suggested to have deep roots in Arab and Muslim masculinities that were produced and projected by colonial and neo-colonial representative systems. Colonising European powers have been suggested to have used the position of Muslim women to rationalise their claims to authority and to justify power relations with Arabs and Muslims as a whole (Said, 1981). Nonetheless, while colonialist accounts pointed to the unequal burden of work borne by rural and working-class Arab and Muslim women outside the home, a fascination with the privileged woman as an, 'enslaved source of sexual pleasure,' permeated European travel literature on the Arab world during the Colonial period

(Lowe, 1991: 38-39). Similarly, practices of the seclusion of women in the family home among upper- and middle-class social groups in the Arab world, functioned as a repository for fantasies of sexual practices forbidden in European societies (Apter, 1992). Among European, male travellers, constructions of the Muslim woman that were 'far more Oriental' than those of Muslim men, were imbued with desires for conquest and possession (Lowe, 1991: 76). Hence, the essential Arab Muslim woman was represented as being, 'undemanding,' and as being in possession of, 'resources [that] were never exhausted,' (Lowe, 1991: 76). European perceptions of Arab Muslim women as belonging to the affective realm of the family, have been linked to condemnatory accounts of Muslim men in Europe that turned around their, 'unchecked sensuality,' and perceived sexual deviancy (Al-Azmeh, 1993: 124). Additionally, depictions of Muslim women secluded within the private and sexual sphere of the familial Ĥaram, served within British Victorian and Edwardian feminist discourses to illustrate the *abject* condition of women whose emancipation was not recognised. Conversely, these representations suggested the cultural fitness of British women to adopt responsibilities in society. Thus as the British women's suffrage movement espoused models of individual feminine agency and self-responsibility, so representations of Indian Muslim women within suffragist literature served to demonstrate how British women were culturally lifted out of the natural condition to which their colonised sisters were confined (Burton, 1994; see 1.3). By castigating Arab and Muslim men for their supposed conduct in relation to Arab Muslim women while simultaneously eroticising Arab and Muslim women, European colonialist fantasies may have served to invigorate an existing public-private divide within Arab Muslim society. Such essentialist representations of Arab and Muslim life later served in nationalist movements as a means of defining Arab Muslim femininity and of establishing the difference of Arab Muslim societies (Said, 1989).

While practices of the seclusion of women within a domestic sphere appear to have characterised the experiences of upper- and some middle-class groups, the same practices required large numbers of working-class women enter the public sphere of work to sell goods and services in the homes of more privileged women (Carapico, 1996). Hence, social class and economic attainment served to determine the negotiation of public and private spaces within individual families and in the organisation of Muslim women's work. Appearing to illustrate the individual basis of the negotiation of this opposition, a body of work has recently sought to describe how practices of feminine seclusion in the Arab world have not functioned to nullify feminine participation in public life (Fay, 1997; Carapico, 1996; Pierce, 1993; Asad, 1986). Similarly, studies of practices of re-veiling among modern Muslim and Islamist women have sought to extend conceptions of this practice as a symbolic form of

feminine seclusion. By relating this practice to changing contexts of nationalism, intergenerational change and migration, these studies have questioned the assumption that the Ĥijāb functions to signal the domestic status of the feminine body (Afsaruddin, 1999; Zuhur, 1992).

Remaining useful within contemporary cultural and legal discourses – notably those of asylum and immigration to western states - practices of seclusion and suppression thought to characterise women's experiences in Muslim societies continue to serve as sites of feminist activity (Volpp, 2003). In casting the Muslim woman as the *abject* identification against which it defines itself (1.3), feminist discourses in the west function to deny the agency of individual Muslim women and to elide the particularity of their experience (Mohanty, 1988). Where western feminisms have presented an unidividuated, third-world woman as the generic symbol of feminine oppression, they have been critiqued for reproducing colonialist representative strategies (Spivak, 1988, see 1.3.2). Accordingly, American feminist concerns relating to the conditions of Afghan women under the Tālibān regime – in 1999 and in 2001 – have been suggested to have deployed the Afghan woman as a cipher of discriminatory practice within American society (Volpp, 2003; Hirschkind and Mahmood, 2002). The promiscuity with which this symbol was used in the American media during the period proceeding the bombardment of Afghanistan in 2001, has indicated the degree to which these representations were divorced from the conditions in which Afghan women lived (Hirschkind and Mahmood, 2002)[8]. Additionally, having failed to engage with profoundly traumatising collective experiences of the Afghan anti-Soviet war, such representations have served to obscure the complex place of the *Tālibān* among the various factions that comprise Afghan society. In this way, colonialist representative strategies that define Muslim cultures against notions of rationality, civilisation, and citizenship have been suggested to be perpetuated in transnational feminist practices through the assumption that individual Muslim women need to be saved from their culture (Volpp, 2003, see 1.7; 2.3; 5.3; 6.3; 6.4).

1.6.3 Seclusion and public participation of the Islamist Mother

Central to the Islamist conception of the social order is motherhood and the seclusion of mothers within the familial sphere (Afshar, 1998; Omid, 1994). Islamists in states such as Iran have consistently maintained the sanctity of motherhood and its spiritual benefit for women by referencing women's natural fitness for the role (Afsar, 1998). In addition to the promotion of conservative gender relations through the discouragement of women's work outside the home, the example of Iran illustrates a second motivation for the promotion of motherhood as women during the war with Iraq were urged to mother sons who would

become martyrs (see 1.7.3; 1.7.4). Hence, a discourse promoting the primacy of motherhood may be seen to represent a means of reinstating primitivist, 'Islamic' values, but has also been suggested to be necessary for the long-term survival of the nation state (see 2.3.4).

Despite the prevalence of constructions of the Muslim mother as a passive actor in the household, important variants within Islamism represent authentic Muslim mothering practices through the socialisation of children. Where motherhood is thus perceived in terms of practices of cultural and religious reproduction, it may provide an Islamist rationale for women's education (2.4.3). Accordingly, among nineteenth century Arab Islamists such as Ahmed Fares el-Shidyak; el-Tahtawi and Mohammed Abdou, the return to an essential Islam was perceived as being dependent on improving feminine behaviour and mothering practices through education (Jaywardena, 1982). Contemporary Islamist manuals for women produced within the Arab world have been demonstrated to urge both modesty and education as characteristics of the Islamic woman (Amir-Moazami and Salvatore, 2003). While women's duties to undertake education are tied to the status of women as the teachers of their children, such popular literature also represents feminine education as a duty owed to the migrant community, nation or to the umma (Amir-Moazami and Salvatore, 2003). In this way, the construction of motherhood as a religious role may extend beyond the family and may thus serve to redefine gender relations in national and international polities (see 1.6.5).

1.6.4 Arab Nationalism and representations of femininity

As in many formerly colonised societies, women's liberation movements in the Arab world emerged at the end of the nineteenth century at the same moment as anti-colonial movements (Al-Hassan Golley, 2003). In common with the position of women in other anti-colonialist struggles, Arab women's activism remained channelled towards nationalist movements until the period following independence (Badran and Cooke, 1990). Women's organised support of Arab nationalism has been indicated by reports of Egyptian women's demonstrations in favour of the Wafd Nationalist movement who gained partial independence for Egypt from the British in 1922 (Al-Hassan Golley, 2003). Similarly, the activities of Huda Sharaawi, founder of the journal *L'Egyptienne* which popularised nationalist concerns together with issues of women's emancipation, suggest wider patterns of feminine participation in Arab anti-colonialist struggles (Al-Hassan Golley, 2003)[9].

Nonetheless, as has been suggested above, the construction of the authentic woman has often served to configure representations of belonging within groups. Accordingly, feminine bodies

and behaviours are also cast as frames on which unified national 'narratives' may be woven (Kaplan et al. 1999; Sharoni, 1995; Parker et al, 1992). In order to promote inter-ethnic unity, nationalist movements tend to recourse to anachronistic family structures within which women are valorised as the reproducers of culture and of continuity (Anderson, 1983, see 1.3). Representations of women's involvement in Arab national communities served divergent functions that have reflected the political contingencies of the nationalist elite. Accordingly, nationalist movements - such as the Ba't in Iraq and Syria and individual figures such as Quasim Amin in Egypt - have deployed representations of feminine autonomy against discourses of tradition (Joseph, 2000, 1991; Ahmed, 1992). However while the anti-colonial struggle – and its advocacy of women's activism - was 'articulated in the language of moral redemption' (Kandiyoti, 1993: 379), following independence, the same discourses were deployed to control expressions of feminine liberty. Hence, while women served in anti-colonialist struggles across the Arab world, during the period following independence, Arab women were more commonly represented as the reproducers of the boundaries of the nation through highly regulated sexual behaviour (Joseph, 2000; 1991; Larcin, 1999; Ahmed, 1992)[10]. A notable example of the use of representations of authentic femininity to contain difference and dissent following independence is provided by the voting rights of women in Egypt. While women were granted suffrage in 1952, they were required to write to request that their names appear on the electoral register. As female illiteracy was high in Egypt, particularly in rural areas, the electorate consisted primarily of educated and urban women. Drawing on deep divisions between urban and rural women – in addition to those along axes of class - the metropolitan and middle class nature of this group was used to deny its status as representative of a larger electorate and to defer its legislative demands (Badran, 1995).

1.6.5 Migration and the articulation of Muslim Maternal Selves

Within conditions of migration and settlement, migrants have been observed to seek to identify essential aspects of belonging to the homeland in order to construct identities around these. These constructions of homeland culture also serve to conceptualise relations with indigenous cultural groups, to establish their difference and to define cultural belonging. Islam forms a crucial nexus of identification among Muslim migrants in Europe and serves as a 'source of emancipation' from identifications projected onto Muslim migrants by the host societies (Amir-Moazami and Salvatore, 2003: 71; Schiffau, 1999; Warner, 1998). As has been discussed above (1.3), within ethnic and cultural groups cultural change is negotiated within existing norms that are enacted individually at the boundary with ethnic and cultural difference. Accordingly, within contemporary Muslim, migrant communities, gender roles and traditions represent a resource for developing strategies of representation that affirm

cultural difference but also serve as a medium to negotiate new identities within the migrant group (Amir-Moazami and Salvatore, 2003).

Central to such practices of negotiating with Islamic tradition is the status of the maternal body (Amir-Moazami and Salvatore, 2003). Hence, the study participants drew on the Qur'ān and Ĥadīt (the sayings of the Prophet) to enhance the status of motherhood as a sacred role and as a social duty for the instruction of children. Among this group, the enhanced status of the Muslim mother was perceived to be guaranteed through practices of entirely covering the hair (Amir-Moazami and Salvatore, 2003). Hence, by obscuring the body and the femininity it is suggested to connote, Muslim mothers may approach the spiritual practices that have been associated with motherhood as an Islamic duty (Amir-Moazami and Salvatore, 2003). By ensuring the social and spiritual formation of children,, Muslim migrant women may enter the public realm of the community and the umma from their locations in the familial sphere. Since the construction of Muslim motherhood among the study participants rested on the dualist categories of body and mind, where Muslim women remained uncovered, access to 'public' discursive spheres does not appear to have been conferred:

'... being uncovered symbolises to be 'open' – a term commonly used by the women... It signifies impurity, since the risk itself to seduce is considered Ĥaram [forbidden]' (Amir-Moazami and Salvatore, 2003, p. 62).

Concerns with maintaining cultural integrity in migration that are suggested through the use of the term, 'openness' to criticise non-veiled women may relate to practices of symbolising dangers to ethnic identity through the treatment of the body that are discussed above (1.3.3). As these practices appear to be recent and to emerge among second-generation migrants, the significance of covering may have related to a perceived need to differentiate the group from the majority population. Through practices of covering, previously non-veiled women may be seen to enact the containment of the cultural difference pressing on the boundaries of the group. Younger women in the group were reported to identify with, 'purified' understandings of Islam – that appear to have extended to Islamism (Amir-Moazami and Salvatore, 2003: 62). Class and regional markers of belonging among the migrant generation were sanctioned by this group of younger women, by whom they were perceived as tokens of inauthentic identification with Islam. Accordingly, where the Ĥijāb was worn among the older generation in accordance with rural or class tradition and thus covered only the rear of the head, second-generation women were reported to urge that it be worn 'correctly' (Amir-Moazami and

Salvatore, 2003: 68). Such inter-generational differences in symbolising cultural belonging through the feminine body also suggest how new identities may be negotiated through the deployment of Islamic tradition (1.3.1; 4.4.4; 4.7; 6.2; 6.5).

Studies have not specifically addressed the salience of Islamism among Arabs in the UK. However, where processes of Islamisation have begun, they are likely to be reinforced by the bifurcation of British and British Muslim identities as a result of British involvement in the war and occupation of Iraq. A further factor that may lead to the radicalisation of these groups are the highly publicised tensions within relatively homogenous White communities in which Muslims of Pakistani origin form a visible and vulnerable minority (Kepel, 1995; Al-Azmeh, 1993). Appearing to reflect the work on Muslim migration and inter-generational change discussed above, a study of the Jamaat-i-Islam-i in Britain has associated cultural imperatives to reproduce the boundaries of migrant groups through maternal instruction with the social advancement of both men and women through education (Andrews, 1993)[11].

1.7 Embodied experience and the configuration of Arab Muslim feminine selves.

The use of the fabled medical examination discussed above (1.5.3), has suggested that women in diaspora may configure highly individuated identities around accounts of their embodied experience. Nonetheless, within feminist research approaches, dichotomies of public/private space and the perceived binary of secular/traditional practices have served to silence the life-stories of Arab women whose experiences did not conform to such systems of categorisation (Afshar, 1998). More recently however, post-colonial, feminist phenomenologies have begun to be used to explore how women narrate and understand themselves within various cultural discourses and within particular social and cultural situations. The first sub-section (1.7.1), introduces the discussion of ways in which Arab Muslim women negotiate normative constructions of femininity by describing a study of the consumption practices of Palestinian feminists in Haifa. The following sub-section (1.7.2), considers the self-representations of women as the mothers of soldiers and 'martyrs' within radical Arab nationalist groups and also traces highly ambivalent patterns in the life stories of politically active women in these groups. Within the final sub-section (1.7.3), patterns of articulating feminine identities through constructions of maternal suffering are discussed in relation to studies of women's devotional behaviour in Christian Mediterranean societies. Differences in the Islamic and Christian construction of women's *abject* status are considered

as these relate to suffering and to sexual behaviour, while similarities between discourses of maternal suffering and those of feminine embodied resilience are also discussed.

1.7.1 The negotiation of tradition and Palestinian feminist identifications

Within the context of political conflict, the desires of Arab Muslim women to preserve the cultural boundaries of the group may coexist uneasily with the need to establish autonomy and freedom of movement in order to engage in political action. Faier (2003) has considered the consumption practices of Palestinian feminists in Haifa in order to explore how these individual women accommodated divergent models of femininity in their actions. Having examined the consumption of intimate items such as tampons, razors, and birth control in addition to more publicly conspicuous goods such as cell phone and cars, Faier related these practices to discourses of feminine agency and communal responsibility that surrounded questions of virginity, custom, and medical knowledge within the Palestinian context (see Chapters 2 and 4). Similarly, goods such as cell phones and cars were perceived by the Palestinian feminists interviewed as a means through which to assert control over personal and social space (Faier, 2003). An example discussed by Faier concerned the possibility that women may accept phone calls from members of their family while engaged in illicit social or sexual activity. As is suggested by this account, within narratives of illicit action, the embodied self was divorced from the mind. Such practices of the elision of embodied experience in 'public' accounts were suggested to have been fundamental to producing identities that offered liberating possibilities to women (Faier, 2003). While tradition was circumvented through these consumption practices, an additional focus of the study concerned the deployment of discourses of tradition as a means of constructing identity among Palestinian feminists themselves. Faier suggested that traditions such as honour ('ird), and the binary opposition of public and private experience that structure representations of feminine sexual behaviour as the source of honour, were deployed by women in this group to distinguish a Palestinian identification from that of Jewish or Israeli feminists (Faier, 2003). In this way, Faier illustrated how women's uses of the typologies of body/mind, tradition/modernity in their accounts constituted a positional and pragmatic practice. The participants' uses of these discourses thus emphasises broader ways in which locality and conflict intervene in women's narration of gender identities.

1.7.2 Narratives of motherhood as a practice of national resistance

Arab Muslim women in situations of conflict, such as that existing in Israel/Palestinine have been culturally represented - and have represented themselves - as the producers of soldiers and 'martyrs' (Sayigh, 1993). Such self-representations among this group of mothers have also contributed to discourses of feminine resilience in Arab and Islamist radical politics in Syria (Shabaan, 1988). A more nuanced pattern however has emerged from studies of life-narratives among Palestinian women. In researching the life histories of these groups who had settled in refugee camps in Lebanon, Sayigh (1999), explored the uses of dominant discourses of femininity within each speaker's life story. Within the older generation, women's life histories consistently portrayed heroic motherhood through examples of 'Śumūd,' or the capacity to bear loss and hardship (Sayigh, 1999:180; see 4.2.3; 4.7; 6.3; 6.5). These accounts also contained unexpected instances of sexually explicit discourse – that Sayigh termed, 'za'rani' and that were commonly shared among older, married women (Sayigh, 1999: 182). Having associated the discourse with rural identifications, Sayigh attributed its decline between the periods of her visits to the urbanisation of the camps and to urban drives to respectability (Sayigh, 1999: 18; see 4.4). While some accounts of radically enfranchised women's identities were discussed, the accounts of former resistance cadres recounted highly ambivalent experiences of returning to maternal and domestic roles. Among a further group that had not subsequently married, perceptions of the constrictive nature of gender roles in marriages within the camp co-existed with a sense of the loss of the experiences of motherhood and with the suppression of (hetero)sexual desire.

1.7.3 Women and ritual suffering in Christian Mediterranean Societies

Ethnological and anthropological discourses have consistently perceived that Mediterranean cultures are organised around the opposing concepts of honour and shame. Within this cultural system, women and their bodies have been understood to take on the signification of potential sources of shame to the family (Brandes 1987; Peristiany 1966). Nonetheless, commentators have pointed to important differences relating to the kinds of shame inscribed on women's bodies in the Christian and Muslim Mediterranean. While Muslim feminists have maintained that an active understanding of sexuality represents the defining feature of femininity in Islam, work on Catholic and Orthodox Mediterranean societies has taken maternal suffering to represent the normative condition of women (Magrini, 1986, 1998; Dubish, 1995; Abu-Lughod, 1993). Despite these clearly indicated differences in the construction of femininity across the Mediterranean region, women across the region may perform similar gendered behaviour to gain expressive space in the public sphere.

In the Calabria region of Southern Italy, during the period of holy week processions that involve both men and women enact the actions of Christ and the Madonna (Magrini, 1998). Within these events, women's symbolic roles are differentiated from the more active roles of men as women carry on their heads '*cinti*' that contain grain or candles and that represent nurturance and redemption. An additional practice that may serve to produce gendered discourses of pain during holy week relates to growing grain in a dark room. The pale shoots that are produced are believed to represent death through the metaphor of food – traditionally prepared by the mother. The association of these withered plants to constructions of suffering motherhood is emphasised as these are placed on altars together with depictions of Christ or the Madonna (Magrini, 1998). On the night before Good Friday in two separate rituals, the 'work' of suffering reaches its culmination. While women gather in the church to perform the lament of the Madonna for her dead son, young men perform acts of self-flagellation. The suffering of the men is then symbolically offered to the women of the community - and to the Madonna - by the young men who daub their blood on the doors of the church (Magrini, 1998).

Within Orthodox and Catholic Mediterranean societies, pilgrimages also support women's identifications with suffering through patterns of devotional behaviour that appear to involve gendered humiliation. Ranging from walking barefoot, to crawling and to dragging the tongue along the ground, ritual behaviours performed by women also include displays of irrationality such as breast-beating, shouting, losing consciousness, and repeatedly invoking the Madonna (Dubisch, 1995; Brandes, 1980). Often accompanied by the singing of songs that praise the power and beauty of the Madonna and that conclude by requesting grace, rituals of pilgrimage would appear to provide a privileged public context in which to express women's lived experiences of suffering (Magrini, 1986). Such practices of redemptive suffering are mirrored to some extend in Shi'a practices that mark the anniversary of the death of the imam Husayn. Proceeded by fasting, the anniversary, ('āšūrā'), is commemorated by a penitentiary procession during which the community seeks to atone for the guilt for failing aid Hussayn to resist his enemies during his final battle. Some penitents, mostly young, single men produce displays of suffering on their bodies through self-flagellation and through cutting their bodies with knives and razor blades (Ayoub, 1978).

The significance of maternal suffering in the Muslim Mediterranean and the Arab world is less clear than that within Christian Mediterranean societies. Nonetheless, studies describing displays of masculine suffering among Shi'a groups, together with studies of militarised discourses of suffering motherhood among Palestinian women discussed above, may suggest

that wider Mediterranean patterns of enacting maternal suffering also serve to establish cultural belonging among these groups (Sayigh, 1993; Shabaan, 1988). Patterns of ascribing cultural meanings to feminine suffering will thus be discussed below as they relate to representations of labour pain (4.7; 6.2; 6.5).

1.8 Conclusions and review of research issues

The literature reviewed above has suggested that identity is constructed through narratives of experience that are produced at the interface between self and the embodied other (Ricoeur, 1990, 1984; Bakhtin, [1965], 1986). Ethnic identity has been suggested to be constructed by individual actions at the boundary with other collectivities where the interaction of both actors is maintained within broad cultural norms or traditions (Barth, 1969). Cultural systems of organising experience may be traced through exploring the opposition and potential resolution of concepts within the story line of myths (Lévi-Strauss, [1958], 1963). Conversely, the cultural schematisations of experience that are contained in language, may be rendered incomplete through bringing individual experience to bear in acts of reading cultural, ' texts' (Ricoeur, 1973). Where the body represents the structure of society, accounts of its transgression may release potentials for social change (Bakhtin, [1965], 1984). Conversely, the ritual treatment of openings on the body may serve to contain symbolic dangers to the group (Douglas, [1966], 2004). As birth confers membership of cultural groups, feminine reproductive bodies have a particularly vulnerable symbolic status as incursion into the group may be symbolised by sexual intercourse (Douglas, [1966], 2004). Similar notions of transgression may be associated with physical openness during birth.

Colonial societies have produced narratives that justify their power through systems of representation that project on colonised individuals and societies identifications that are the inverse of those with which the colonising culture is invested (Fanon, [1961], 1983). Such representations of colonised societies through their association with nature, the body and irrationality served to represent colonised societies as being in need of tutelage. The same system of representation represented colonised individuals as non-subjects against which European subjects were defined (Spivak, 1999; Said, 1979). Characteristics that were understood to have prevented colonised people from attaining the status of subject were termed abject as they served to permanently exclude individuals from notions of self-responsibility and participation in society (Spivak, 1988; Kristeva, 1982).

Similar representative strategies have been used to control gender identities within European societies and hence to control women's access to power. Consequently, a fundamental project for post-colonial and feminist theory has been to theorise and articulate identities that have previously been controlled through their association with *abjection* (de Beauvoir, [1944], 1997). The formulation of *écriture féminine* (women's writing) celebrates the liberating potential of mediating feminine bodily experience in language and has similarities to understanding of the disruptive potential of the body described above (Irigiray, [1984], 1993; Bakhtin, [1965], 1986; Kristeva, 1980). Nonetheless, in common with the formulation of *Carnival*, such approaches have failed to address the cultural models within which embodiment is experienced. Further developments in feminist theory have continued to diverge between approaches formulated within the dualist categories of body and mind and those that attempt to collapse this dichotomy. Formulated inside the binary, a strategy of resistance to normative identifications proposed by Butler (1990), has envisaged the parody of the system of representation that produces gender identifications. In contrast, work on feminine *disciplines* of diet and exercise has sought to theorise individual embodied experiences of normative femininity (Bordo, 1993; 1987). An approach that perceives embodied experiences as existing within a web of natural and cultural relations to the world has been developed through adapting phenomenological understandings of being-in-the-world (Bigwood, 1999; Merleau-Ponty [1945], 1996; [1968] 1963). By locating feminine selves within this framework, women's negotiation of cultural selves in their accounts of embodiment may be traced.

By characterising the experience of migrant groups as being formed within multiple cultural fields, approaches to theorising transnational identity offer means through which to examine the individual construction of migrant or hybrid selves within acts of storytelling (Inowlocki and Lutz, 2000). European colonialism in the Arab world has produced pervasive representations of Muslim and Arab societies in which cultural practices and beliefs become interpreted as tokens of irreducible difference and irrational traditionalism. Colonising powers made use of representations of enslaved and eroticised Arab Muslim women to justify their incursions in the Arab world. Accordingly, the identities of Arab and Muslim women who have migrated or settled in post-colonial societies may be negotiated with such representations of sensuality and seclusion and may involve the manipulation of the public-private divide. Similarly, studies of practices of the representation of Muslim women in the discourses of western feminism, have suggested that colonialist strategies of projecting *abject* identities onto Black and minority ethnic women continue to be used to control the identifications of these groups (Volpp, 2003; Spivak, 1987). Islamist and nationalist

discourses in the Arab world that configure femininity around the functions and practices of motherhood may be partially understood in the context of discourses of essentialism and difference that derive from the conditions of anti-colonial struggles. These may also relate to the binary relation of public and private within which authentic Arab and Muslim motherhood is imagined (Al-Azmeh, 1993; Joseph, 1991). Despite the prevalence of representations of the Muslim mother through her passivity, a position emerging from international Islam that provides a rationale for feminine education emphasises the imperative of ensuring the preservation of cultural and religious difference through mother's practices of instructing their children (Amir-Moazami and Salvatore, 2003). Such interpretations of the spiritual duties of 'Islamic' motherhood appear to gain significance following migration and among the first generation born in diaspora. As claims to education may come to be made by reference to the spiritual and cultural practices of, 'Islamic' motherhood, so the formulation of 'Islamic' motherhood within the body-mind binary became apparent in concerns regarding the status of the maternal body. Having urged that older women should completely cover their bodies and their hair, women within a second-generation group suggested that the, 'open' bodily states of these older women signalled their failure to engage with the precepts of Islam. Concerns surrounding the uncovered state of older women were also be understood to symbolise danger to the identity of the migrant group (Amir-Moazami and Salvatore, 2003). Parallels and differences between the cultural reproduction of maternal suffering in Christian Mediterranean societies and in parts of the Arab Muslim world suggest further aspects of the cultural symbolism of maternal embodiment (Magrini, 1998; Shabaan, 1988). Similarly, phenomenological work on the negotiation of Arab and Muslim femininities has raised additional questions concerning the narration of motherhood, femininity and embodiment that will be discussed in Chapters 4, 5 and 6.

In the light of the literature reviewed, the first research question was formulated. This was concerned with:

- How do Arab Muslim women negotiate with symbolic maternal bodies in their accounts of motherhood and of birth in the London NHS?

The remaining research questions will emerge from the discussion in the following chapter (2.7).

Notes to Chapter 1:

[1] The term, 'diaspora' is used without capitalisation to denote any large-scale migration of people who continue to maintain links with the homeland and with compatriots in migration.

[2] Since the cultures of European colonising nations are not considered as having represented homogenous entities, the term 'west', is used without capitalisation. This usage is adopted after that of al-Hassan Golley (2003).

[3] 'Islamism' is used throughout to denote versions of political Islam that seek to impose a return to primative Muslim values through establishing Islamist states. As such, after Al-Azmeh (1993), the terms Islamism, radical Islam and 'fundamentalism' are considered to be interchangeable.

[4] Bakhtin's understanding of the relation of the self to the world envisages a private (or idem) self, that he terms the I-for-myself, as deriving its definition from relations with others and thus existing also as an I-for-others or (ipse-self).

[5] This model appears to have introduced to social anthropology a new awareness of the consequences of individual social interaction in establishing 'ethnic' difference. Nonetheless, Jenkins has noted that the foundational perception that the boundaries of ethnic identities are continually contested and redrawn that is described by Barth, had previously been described by anthropologists such as Nadel (1951, 1957 - cited in Jenkins, 1996, pp.91).

[6] The transliteration used throughout the thesis is adopted from that used by Bosworth, van Denzel, Heinrichs and Leconte, in *The Encyclopaedia of Islam* (1997) (vol.ix). In the case of 'ḥ' and 'ā', approximate European symbols were substituted for the phonetic symbols.

[7] Each of what now constitute Arabic states with the exceptions of Morocco and parts of the Arabian peninsula (Yemen), were under Ottoman rule from the sixteenth to the end of the eighteenth centuries (Hourani, 1991).

[8] These representations were reported to have ranged from the inclusion of the monologue 'Afghanisatan is Everywhere' in the *Vagina Monologues* to a proposal that protesters against the exclusion of women from the Augusta National Golf Tournament wear green *burquas* (Volpp, 2003).

[9] Sharawi's case is referenced together with women's support of the *Wafdist* movement due to the central cultural place occupied by Egypt in the development of Arab nationalism (Al-Hassan Golley, 2003). Sharaawi was also the founder of the *Egyptian Women's Federation*, and is considered by as a major early Egyptian feminist (Badran, 1986). However, her identification with the Nationalist struggle has been suggested to have lead to her devoting a large part of her autobiography to the defense of her father, considered a traitor for his dealings with the British (Al-Hassan Golley, 2003). Additional suggestions of Sharaawi's nationalism have been made based on her decision to dictate her memoirs in Arabic, a language which she could not write (Al-Hassan Golley, 2003).

[10] Women have participated in Nationalist struggles throughout the Arab world. See Fanon's *Studies in a Dying Colonialism* (1965). Women also instrumental in anti-colonialist struggles in Syria, Egypt, Yemen and Palestine – see Fluerh-Lobban 'The Political Mobilization of Women in the Arab world' in J. Smith (1980) (editor) *Women in Contemporary Muslim*

Societies. See also Molyneux(1979), ' Women and Revolution in the People's Democratic Republic of Yemen (*Feminist Review* vol. 1) and Haddad, 'Palestinian Women : Patterns of Legitimisation and Domination' in : K. Nakhleh and E. Zureik (1980) (editors) *Sociology of the Palestinians*.

[11] In advocating that that Islam is compatible with models of individual feminine agency, this position appears to be supported by a stream of 'Islamic feminist' theory that may be illustrated by the work of the Moroccan theorist, Fatima Mernissi (Mernissi, 1987). In seeking to illustrate the egalitarian premises of early Islam, Mernissi describes how 'true' Islamic commitments to equality became compromised by the political contingents of the Arab male elite. Nonetheless, in so doing, her critique functions to elide much of Islamic history and hence falls unwittingly into the Islamist trap of appealing to a primitivist utopia. Hence, it would appear that she is disabled from placing Qur'anic proscriptions in their historical contingencies and are trapped into reinforcing their normativity (Rhouni, 2002). A more robust critique of the effects of Islamist normative practices on Muslim women among Muslim feminist theorists, would appear to be exemplified by Ahmed's sociological perspective. By locating itself outside the tradition of textual scholarship Ahmed's work is able to critique Islamism as the product of a particular historical moment - understanding it as a social reality. Hence is released from an a-historical perspective on revelatory truth that may do little to problematicise and publicise the conditions of women's lives.

Chapter 2:

The construction of legitimate knowledge of the body in the NHS and among Arab Muslim women in the UK

2.1 Introduction

This chapter aims to suggest processes through which knowledge of the body are established as being culturally legitimate. It will characterise aspects of the Iraqi, Moroccan and Yemeni communities in London that will be used to interpret patterns across participants' accounts, and will describe the regions from which participants' or their families had migrated (2.2). The core of the chapter describes competing institutional discourses that frame the information-giving encounter in British maternity services. Accordingly, the third section (2.3), will explore the basis of conceptions of equity in British public services. It will outline negative rights from discrimination and from unsought intervention and will suggest that these may be negotiated by health professionals and patients from positions of that are culturally and politically fixed. In order to characterise an important means of positioning women from Black and minority ethnic groups within these encounters, the chapter will consider the complex legacy of Enlightenment conceptions of justice. By exploring the cultural and gender characteristics of the subject of the law, it will suggest how health professionals may draw on concepts of individual self-responsibility to withdraw from commitments to the equitable care of women from Black and minority ethnic groups. The section will close by considering how maternity information may function as a form of legitimate knowledge of the body by configuring individual embodiment to reflect the symbolic organisation of society. By introducing an understanding of the function of biomedical knowledge in establishing a disciplined society, it will consider ways in which maternity information may invite women to survey their own embodiment from positions exterior to it. Similarly, by exploring a historical study of obstetric literature, it will consider

how maternity information may emphasise certain functions and actions that reflect the role of women in society. Set against such conceptions of the responsible subject, maternity information and the biomedical body are perceptions of linguistic, narrative and collective knowledge and the construction of the family as the social institution in which the self is negotiated. Common perceptions of the status of visual images in Islamic legal opinion and in Muslim philosophy will be considered in the following section (2.4). The construction of social knowledge in oral traditions will be discussed and relations of authority within the Arab family will be described as these may present opportunities or barriers to maternity storytelling in London. The fifth section (2.5), will explore ways in which the construction and uses of consumer health information endorse the biomedical models of the body and may enjoin wider patterns of symbolic behaviour onto women. Parallel developments in NHS policy will be discussed and a critique of discourses of patient empowerment will be explored. An alternative paradigm for exploring communication in maternity services addresses issues of gender and class identity in the communication of midwives with patients and with obstetricians. This approach will be discussed as it suggests how notions of the responsible subject have been used by midwives to justify practices that discriminate against less-educated White women. An increased awareness of the interpersonal dimensions of communication in maternity services among women from Black and minority ethnic groups will also be explored in relation to possible practices of discrimination against these groups. Studies of exclusionary communication practices among health professionals will be considered in relation to similar patterns of producing cultural identification and difference. The limitations of recent studies of the uses of maternity information among Black and minority ethnic groups in the NHS will be described in section 2.6. The final section, (2.7) will summarise salient points that have emerged from this discussion and will outline further research aims that have arisen from the literature reviewed.

2.2 Arab Muslim participant groups in London

Iraqi, Moroccan and Yemeni migrant - and second-generation women migrants in London formed the Arab Muslim participant groups. While the term, 'Arab Muslim' women is used within this study to denote the totality of these groups, the backgrounds or experiences of participants within these groups were in no way assumed to be homogenous. Similarly, while the terms Iraqi, Moroccan and Yemeni are used to denote these groups, no attempt has been made to locate the views of participants in relation to issues in these homelands or family homelands. Nonetheless, an outline of factors leading to migration for each participant group is provided here together with details of the regions from which participants or their families

had migrated. This information will be augmented with demographic data and biographical sketches in the following chapter and will provide the basis for the discussion of participants' representations of national, regional and class belonging (3.2.1; 3.4; 4.7; 6.2; 6.4; 6.5).

In addition to a low level of economic migration, political events in the Arab world have led to the forced migration of a number of distinct Arab groups that have settled in London (Al-Rasheed, 1994). Home Office figures show that the majority of asylum-seekers are young and male (IND, 2002). However, several Council of Europe conventions, such as the European Social Charter (1961), the revised European Social Charter (1996), and the European Convention on the Legal Status of Migrant Workers (1977), in addition to the United Nations Convention on the Rights of the Child (United Nations, 1989), encourage member states such as the UK to promote the right to family reunion. This right extends to individuals who have obtained refugee status or subsidiary protection such as indefinite leave to remain in the UK (United Nations, 1951). Established refugee groups such as the Iraqi and Palestinian communities therefore have a high proportion of women who entered the UK as the wives or daughters of refugee men.

Iraqis

Accurate UK census data on the extent of the Iraqi population in the UK is not available, however the Iraqi community in the UK was estimated to number between 70,000-80,000 individuals during the early 1990s (Al-Rasheed, 1994). Due to evolving tensions in Iraq, this estimate is likely to considerably underestimate the number of Iraqis currently resident in the UK. Similarly, while the total number of principal applicants for asylum from Iraq between 1994 and 2002 stood at 35, 350, this figure excludes other family members (Home Office, 1994 - 2002). Individuals who have not declared themselves to UK authorities and those who have remained after their asylum applications have been refused may also represent a non-negligible proportion of the Iraqi community in London.

Iraqis in London do not form a cohesive unit and are divided along the lines of social class, ethnicity, political and religious affiliations. The majority of Iraqis in London define themselves as Arabs in that their first language is Arabic (Al-Rasheed, 1994). Refugees have been arriving from Iraq since the 1960s when a series of revolutions, *coups d'état* and purges forced those involved in opposition groups to migrate (Batatu, 1978). Migrants in this group belonged to the Sunni professional and land-owning elite (Batatu, 1978). The nationalisation of land and major industries in Iraq undertaken by the *Ba't* regime also contributed to the migration of members this group (Batatu, 1978). Following the outbreak of war with (Shi'a)

Iran, Shi'a first came to be represented in considerable number among new arrivals. As suggested above, the volume of migrants has greatly increased due to the effects of economic sanctions and following the first and second invasions of Iraq (1991, 2003). Accordingly, since the early 1990s, larger numbers of migrants from Shi'a working-class communities have settled in Britain, thus altering the composition of the Iraqi community in Britain to reflect more fully the diversity of the population of Iraq (Batatu, 1978). Having all received secondary education and having been suggested to have migrated from middle-class residential suburbs of West Baghdad, the urban and educated composition of the Iraqi participant group reflected that of the previous Sunni exile community (3.2.1). Nonetheless, the effects of the arrival of other Iraqi groups will be discussed as these related to participants' construction of ties of belonging to Iraq, to Baghdad and to the Iraqi community in London (4.4; 4.7; 6.2; 6.4; 6.5).

In common with other Arab migrant groups, the majority of Iraqi Arabs have settled in West London with many resident in Kensington, Westminster, Hammersmith and Ealing. Having reflected this pattern, participants who rented local authority or housing trust accommodation had settled in the established communities of Kensington and Westminster. Nonetheless, those renting private accommodation, had settled in the suburbs of West or North West London.

Yemenis

Conflict between North and South Yemen has been intermittent for over thirty years. In 1970, the government of Southern Yemen (People's Democratic Republic of Yemen) developed a Marxist single-party system, leading to the migration of hundreds of thousands of Yemenis from the south to the north (Medea, 2001). The two countries were formally unified as the Republic of Yemen in 1990 (Medea, 2001). In common with Sudan and Mauritania, Yemen has experienced rapid urban growth and rural depopulation that has been accelerated by climatic crises (Kharoufi, 1996). Processes of desertification in the East and Central regions have thus obliged farmers to migrate to Yemeni towns and cities and have also contributed to patterns of increased international migration (Kharoufi, 1996). While the majority of Yemenis have migrated to the Gulf states – most notably to neighbouring Saudi Arabia - a high population growth rate (3.4%), and the lowest average income in the Arab world may also present factors encouraging international migration (Medea, 2001; Birks, Seccombe and Sinclair, 1986).

The ethnic composition of the Yemeni population is predominantly Arab but also includes Afro-Arabs, South Asians, and some Europeans (Medea, 2001). Islam is the predominant religion and around half the population of the former northern state belong to the Zaydi (Shi'a) sect. Around half the population of the former People's Democratic Republic of Yemen belongs to the Shaf'i (Sunni) sect (Medea, 2001). Small Jewish, Christian, and Hindu groups also exist (Medea, 2001).

The study participants belonged to the Shaf'i sect, however one (Sudanese) Shi'a woman contributed to the exploratory focus group (3.2.1). Yemeni participants had migrated from the Sa'dah region in the north east of Yemen or from the region of San'a. Among participants from San'a, some also appear to have previously migrated from rural areas (3.2.1). The Sa'dah region contains some arable land but consists mostly of dry, highland pasture and scrub. Within the Eastern and Central areas of Yemen, families or tribes own rights over parcels of pasturage on which they graze their animals for limited periods (Kessler, 1988). This system of rotating grazing patterns serves to protect pasture land but leads to increasingly nomadic social patterns during dry periods (Kessler, 1988). Despite the harsh conditions of life within this region, participants' reported level of education was considerably higher than is suggested by estimates of female literacy at 26% (1990 EST.; CIA, 2001). Nonetheless, since participants in the exploratory focus group gave oral consent and all participants in individual interviews signed their names with a cross and used the interpreter or researcher to complete a form demanding demographic information, it was not possible to definitively establish whether any participants were illiterate[1]. Nonetheless, given the relatively high level of education reported by the group, it is unlikely that the level of first-language illiteracy exceeded five participants in the focus group (YFG1; YFG4; YFG5; Y1; Y7).

Moroccans

As is the case in Yemen, processes of urbanisation in Morocco are multidimensional and are also linked to rapid population growth (CERED, 1999). Similarly, rural development has been curtailed by labour shortages. Consequently, investment capital has been diverted from rural areas to urban centres and smaller towns (CERED, 1999). In common with Yemen, rural-urban migration has also contributed to a greatly increased level of international migration. Given the proximity of Morocco to Spain, most of these groups chose to migrate to cities within the EU (CERED, 1999).

Morocco's ethnic composition consists almost entirely of Arab-Berbers (99.1%), with Jews and others comprising the remainder (CIA, 2001). Berbers are the descendants of North African's pre-Arab population (Hourani, 1991). A minority (4 million), of this group maintains a distinct ethnic and linguistic identity (Medea, 2001; Hourani, 1991). Islam is the religion of a large majority of Moroccans (98.7%), including Berber groups with the majority belonging to the malachite sect of Sunni Islam (Medea, 2001).

Participants in the study were Arab-Berbers and similarly belonged to the malachite sect. Participants or their families had migrated from the Rif Mountains and the Anti-Atlas range. The populations of these areas depends on pastoral agriculture and handicrafts (Parish and Funell, 1995). The average income of the populations of mountain areas is the lowest in Morocco while rates of maternal mortality are highest there (Kingdom of Morocco, 2004). A further group of participants or their families had migrated from the arable and fruit-growing region of Agadir (Kingdom of Morocco, 2000). Despite apparent differences between these regions, participants' depictions of women's rural work suggested similarities in the construction of ties to these regions (4.2.2; 4.2.3). Female illiteracy in Morocco stands at 31% (1995 est, Medea, 2001), however most migrant Moroccan participants had received primary-level education. Two older, migrant women were illiterate in both English and Arabic (M2; M4) while one (M2), had learnt to read and write Arabic while in London.

2.3 Information and competing discourses of authority in the medical encounter

This section traces the origins and uses of discourses of equality in British public services and explores the construction of maternity information and its approved uses within British medical institutions. The first sub-section (2.3.1), discusses the liberal roots of commitments to equity in public services and outlines legal rights and commitments to equality within NHS policy. The second sub-section (2.3.2), discusses how the formulation of the Social Contract sought to reconcile tensions between individual freedom and society through constructing a notion of the subject of the law. By focusing on the representative strategies used to construct the responsible individual, it will consider how the conception of a public sphere of justice rests on the creation of non-responsible subjects to whom rights were not awarded. The third sub-section (2.3.3), examines how wider configurations of authority in British society may determine the functions of maternity information provided to women.

2.3.1 Liberalism and rights within the law

Liberalism has proposed a model of social organisation that is founded on an understanding of liberty as the normatively basic condition in which human selves exist. Accordingly, Locke described the natural condition in terms of the individual's freedom of action:

'... it is a State of perfect Freedom to order their Actions... as they think fit... without asking leave, or depending on the Will of any other Man' (Locke, [1689]1960 p. 287).

Having understood freedom to represent the foundational human condition, liberalism also entails freedom for all through a concept of equal rights. In attempting to theorise the nature of the relationship between individual freedom and the rights of all, Hobbes ([1651] 1946), and Locke ([1689]1960), developed the theory of the Social Contract. This model proposed that a just society was born from the individual's submission of their personal desires to universal reason. While the contract was considered to be entered into by individuals who existed freely in a state of nature, by deciding to forgo authority over their freedom, these individuals were perceived to enter into society. Given the significance of this step in determining the status of individuals, the decision to transfer authority from the self, may be described as the fundamental 'responsible' action. Envisaged by Hobbes and Locke, the Social Contract primarily represented a means through which individuals were protected from the violence of others. The theory reached its most developed political form in the thought of Rousseau ([1762], 1973), who proposed that responsible individuals participate in society on the basis of an original contract through which they invest authority over their own liberties in the State that is charged with the regulation of the rights of its members ([1762], 1973).

Having established the principle of equal rights protected by the law, liberalism has provided the informing context for notions of equity in British public services. Tensions between the individual and society are thus contained within structures of obligation within which the rights of women from Black and minority ethnic groups are, ideally, guaranteed. In the first instance, the freedom of these groups to use NHS maternity services are protected by the right to free and equitable treatment that is extended to individuals normally resident in Britain (Gerrish, Husband and Mackenzie, 1996). Patients' rights to receive equitable and appropriate care regardless of their ethnic origins are also protected by *The Race Relations (Amendment) Act (2000).* Having adopted the tenets of *The Macphearson Report* (1999), which identified systematic discriminatory practices against Black people in the provision of police services in London, the *Act* focuses on indirect practices of exclusion. Accordingly, it confers duties on public bodies to develop and implement policies promoting racial equality

and obliges these bodies to assess how their existing practice served to ensure equitable and appropriate care to users across ethnic and cultural groups. The principle of the Act was incorporated in the *NHS Plan (2000),* through the notion of, 'culturally appropriate advice' (Department of Health, 2000:27). Having extended protection to cultural difference within NHS services the notion of, 'culturally appropriate,' care represents an important departure from previous discourses of positive rights in the health service that protect individuals' freedoms to perform actions rather than their freedom from the actions of others. A further change in the balance of positive and negative rights that has important implication for Black and minority ethnic women was introduced by *The Human Rights Act 1998* (The Stationery Office, 1998), which provides patients with legislative protection against unsought interventions through a strengthened concept of informed consent (General Medical Council, 1999, see 4.5.2; 4.5.3). Having associated the protection of bodily integrity with the transparency of health professionals' communication with patients, the provisions of the *Act* have served to highlight the political environment of information-giving. Nonetheless, the positions from which health professionals perceive the needs and of culturally-diverse groups are politically and culturally opaque. The conditions that shape the provision of appropriate care and practices of establishing informed consent thus remain largely unknown (2.6). Nonetheless, by exploring health professionals' accounts of the information-giving encounter, this study will seek to characterise the institutional and cultural environment in which rights to equitable care may be enjoyed.

2.3.2 The social contract as a discourse of exclusion

Potential inequalities in the provision of rights within medical encounters may be traced to three dimensions of the conception of the subject in the state of nature that lie at the core of the liberal political tradition. Firstly, Hobbes and Locke perceived that the Social Contract existed between men who owned property and understood the contract to serve to preserve the privileges of property (Macphearson, 1962). Locke understood those who did not own property to live by selling their labour. Given the material conditions in which these groups lived and given their need to compete with other individuals in the labour market, Locke considered that non-property owning men were prevented from developing the rational faculties necessary to enter into the Social Contract. Accordingly, while Locke did not suggest that the European working-classes were permanently incapable of responsible public action, he perceived that they were nonetheless confined to a state of nature prior to the Social Contract (Macphearson, 1962). The status of working-class European men within the state of nature thus served to define that of property-owing men, who in divesting themselves

of their desires were thus invested with the status of free subjects in society. Secondly, having envisaged an individual that cedes individual sovereignty to universal reason as the basis of a just society, Social Contract theorists also conceived that individual embodied desires led women to fail to fulfil their part in civic society. Thus, while women were constructed as being free - notably through their acceptance of the marriage contract – they were also perceived as being unable to leave the state of nature (Pateman, 1989). In order to accounts for the ambiguous position of women in public life, the family was constructed as a private sphere to which rights did not extend (Pateman, 1989). While women's position in the Social Contract was ambiguous, colonised men remained entirely outside the model of civil society that it described (Pateman, 1989). These groups have been suggested to have been subject to a parallel 'racial contract,' (Mills, 1997). Having been defined through geographical and anthropological discourses, native men were marked by their places of origin as European men were not (Mills, 1997). Thus constructed as belonging to the state of nature, the male native of the Enlightenment imagination was understood to be incapable of the responsible action necessary to attain the status of a full subject and to enjoy rights and liberties (Mills, 1997). Where the public status of women from Black and minority ethnic groups remains determined by familial and sexual relations, and by perceptions of their racial or cultural identity and their educational level, liberal constructions of justice may continue to question the basis on which these groups are awarded rights (Benhabib and Cornell, 1987, see 1.4.1; 1.6.1; 1.6.2; 1.6.3). The study will consider at length how health professional's perceptions of patients' responsibilities construct subjects as the bearers of rights.

2.3.3 Biomedical knowledge, vision and power

As perceptions of the symbolic body have been understood to represent models of societies (Douglas [1966], 2004), so the establishment of biomedical knowledge of the body through the visual perspective of health professionals have been suggested to represent a metaphor for the mechanism of power in society (Foucault, [1975], 1977). Further recalling understandings of the symbolic body, the institutional construction of the body as the object of view reflects the relation of certain parts of society to others. Foucault has offered a model for the coercive use of perspective on individuals who are marginal to society that that was derived from Bentham's model of the Panopticon (Foucault, [1975],1977). Within this imagined prison, each cell and its inmate was conceived as being open to the view of a surveyor positioned in a central tower. Seen from this perspective, the spaces of the cells functioned to frame the inmate's body as the light from the rear window of the cell served to expose him to view. The cell was thus designed as a means to abstract visual knowledge from the body of the inmate.

Nonetheless, Foucault did not imagine the inmate's relationship to authority to be one of simple subjection to the perspective of surveillance. Dominating the view from each cell and associated with the permanent possibility of observation, the observation tower was understood to serve to recruit the inmate into imposing an institutional perspective on his own body. Accordingly, he explained that:

'He who is subjected to a field of visibility, and who knows it, assumes responsibility for the constraints of power; he makes them play spontaneously upon himself; he inscribes in himself the power relation in which he simultaneously plays both roles; he becomes the principle of his own subjection' Foucault, [1975], 1977, p.105.

Thus having perceived himself as the object of institutional vision, the inmate may also be understood to construct a perspective on himself through which to discipline the actions of his body. Having conceived of prisoners as a group whose bodily impulses need to be corrected by acts of will, this model recalls that of *feminine discipline* proposed by Bordo (1993, see 1.4.3). Similarly, as both prisoners and women are constructed as marginal groups within symbolic understandings of society, the imperative that these groups discipline their bodies may suggest the wider role played by the control of the body in society (5.6; 6.3; 6.5). The understanding of vision as a means to establish power offers important latitudes within which to consider the construction of biomedical knowledge as a culturally legitimate form of experiencing the body.

Central to this understanding of the disciplinary functions of biomedical knowledge, are three principal means of control of hierarchical observation, judgement, and the examination. Each of these techniques was connected through the observation of health professionals. Accordingly, Foucault understood the examination of patients to combine, 'the deployment of force and the establishment of truth' ([1975], 1977: 184). Having thus served to elicit the, 'truth,' concerning the patient's embodiment, Foucault suggested that the examination also served to control patients' behaviour by directing treatments or precautions that patients would later impose on themselves. The construction of biomedical knowledge as a perspective on the body, may thus be reflected in health professionals' construction of information and its uses among patients. As the inmates of the Panopticon were suggested to impose a perspective on themselves through their knowledge of their positions as objects of view, so the use of maternity information may serve to establish a perspective on the body.

Accordingly, scanned images of the foetus may represent a 'truth' concerning a woman's embodiment that may serve to bring her behaviour and her sense of self, under medical

control (4.5; 4.7; 6.2; 6.5). More widely, health professionals' practices of encouraging pregnant women to consider the need to accept interventions during labour may be said to invite women to externalise and objectify their current and future embodied states. Information provided by health professionals to encourage women to minimise potential risks during pregnancy may serve a similar function. Such practices of information-giving through which pregnant women are encouraged to imaginatively project into situations in which their embodiment harms themselves or their foetus will be termed, the 'precautionary mode' within this study (4.3; 4.5; 4.6; 5.4; 5.5; 6.2; 6.5; 6.7). Similarly, uses of maternity information that represent institutional norms within the accounts of health professionals will be termed *proper* (5.2.1; 5.3.1; 5.5.1; 5.6; 6.4; 6.5).

Foucault also proposed that biomedical knowledge of the body functions as a political symbol through directing attention to certain structures and systems (Foucault, [1975], 1977). Accordingly, in a study of obstetric literature in nineteenth-century and early twentieth-century France and Britain, the imperatives of the nation-state to defend its interests and maintain its economy were shown to be endorsed by representations of the female reproductive body (Moscucci, 1990). By depicting gestation and birth as a set of processes that were set in motion by independent systems, women's reproductive efforts were represented to serve to produce a supply of future soldiers and workers. Similarly, in order to represent obstetric practice as a form of patriotic action, women's embodied agency in the process of birth was obscured behind this semi-mechanised model of the biomedical body (Moscucci, 1990, see also 1.6.2). In order to trace ways in which the biomedical obstetric body may determine women's symbolic behaviour in society, attention will be given to references to envisioning the body in the accounts of health professional participants (5.2.1; 5.2.2; 5.4.1; 5.4.2; 5.6; 6.3; 6.4)

2.4 Legitimate forms of knowledge in the Arab and Muslim World

Islamic legal traditions and epistemologies developed from Muslim philosophy, together with oral traditions that persist in the Arab world, may condition perceptions of appropriate forms of maternity information and may determine the uses to which they are put by Arab Muslim women in migration. The first sub-section (2.4.1), describes a school of Muslim philosophy and Islamic legal opinion that has eschewed the use of visual images. Conversely, the second sub-section (2.4.2), considers how the oral tradition may provide a form of culturally-established knowledge through which women may understand their maternity experiences. The final sub-section (2.4.3), explores the institution of the Arab family as the context within which maternity narratives are performed. Divergent views of the potentials of women's

familial storytelling as a normative practice and as a medium for producing counter-discursive embodied identities will also be discussed.

2.4.1 The juridical interdiction on visual Images in Islam

Since Islam is a religion based on revelation, orthodox Sunni epistemologies have emphasised the completeness of available knowledge in the Qur'ān and have sacralised the linguistic form in which it is expressed. Given this understanding of the final nature of the revelation offered in the Qur'ān, orthodox Sunni commentators have considered alternative forms of knowledge have been heretical. While non-Islamic philosophy was used during the Abbasid period (762 – 1055 AD/CE), to produce a synthesis of Islamic thought with wider Muslim philosophy, secular and sacred thought during this period converged on attitudes towards the corruption represented by visual images (Fakhry, 1983). Accordingly, Al-Kindi (801- 873 AD/CE), who is considered as the first major Muslim and Arab philosopher contended that the revelation provided in the Qur'ān was complete (Fakhry, 1983). Nonetheless, after Aristotle's understanding that knowledge of the 'real' (or divine) was obtained through intellectual effort, he directed those who were capable to use conscious thought as a means to arrive at an understanding of the divine order (Fakhry, 1983). While Al-Kindi's directive implicitly served to privilege the intellect over the senses, Al-Farabi (872-950 AD/CE) developed a notion of the divine order that was opposed to sensual and visual knowledge. Al-Farabi derived from Plotinus an understanding that creation continually emanated as a form of thought from the divine origin (Fakhry, 1983). Given this understanding of creation as emanating from the divine origin, Al-Farabi proposed that through steps of directed contemplation individuals could progress towards it and could finally join with it (Fakhry, 1983). Conversely, having been associated with the body and sensuality, Al-Farabi perceived visual images to serve as an impediment to progress towards an eventual union with the divine origin (Fakhry, 1983).

A position that is analogous with that of Al-Farabi within the Islamic theological and juridical traditions, relates to the prohibition of visual images. No such direct interdiction is contained in the Qur'ān, as exists in Judeo-Christian tradition (Exodus XX.iv. Cited in Bosworth et al, 1997). Nonetheless, a highly ambivalent attitude to visual images has developed in Islamic theology and law. The problematic status of visual images appears to have derived from the proximity of the concepts of representing and creating within the Qur'ān, in which the verb śawwara meaning, 'to fashion' or 'form' is synonymous with

bara'a, meaning 'to create'. Accordingly, the creation is expressed by means of these synonymous senses:

'... We have created you, then We have fashioned you...' (śūra VII,10, Cited in Bosworth et al, 1997, p. 889).

Similarly, God is described as Al-xāliq (creator), Al-bāri', and Al-muśawwir (fashioner and in contemporary usage - photographer) (LIX,24). Where God is understood as the primal fashioner, interpretations of the Qur'ān, view human acts of representation as imitations of divine fiat and perceive such acts as deserving punishment. As such, the Ĥadīt state:

'Whoever makes an image, Him will God give as a punishment, the task of blowing the breath of life into it, but he will not be able to do this' (al-Bukhārī, Bury, bāb 104, Muslim Libās, trad 100, Cited in Bosworth et al, 1997, p.889)

The view that figurative art serves to imitate the divine act through art is mirrored in Islamic law (Šarī'a), in which the representation of living things that have rūĥ (soul), is forbidden (Al-Nawawī, 1283; cited in Bosworth et al, 1997: 889). Despite the accepted status of the interdiction on visual images, breaches occurred such as frescoes, and the miniature illustrations that appear in Persian and Turkish manuscripts (Rice, 1993; Grube, 1962).

A more recent understanding of Islamic attitudes to the representation of living forms, has emphasised that early Islamic attitudes developed through interpretations of the life of the Prophet, clash with descriptions of metalwork and textile figures in the Prophet's home. A possible explanation for the prohibition on visual images has been suggested to relate to defensive responses within the Muslim world to the emergence of Byzantine art (Fahd, 1987). The views of these early theologians of Islam have also been suggested to reflect folk beliefs in Arabian peninsula that invested visual images with malevolent powers over individuals who are depicted (Fahd, 1987). Such beliefs in the powers of visual images to endanger individual agency were also reflected in traditions of sending painters to depict an enemy prior to warfare (Fahd, 1987).

In order to explore the effects of this cultural construction of illegitimate knowledge and in order to trace the effects of perceptions of the danger posed by visual images, particular attention will be given to accounts of the uses of scanned images and diagrams among Moroccan, Yemeni and Iraqi participants (see 4.5.2; 4.5.3; 6.2; 6.4; 6.7).

2.4.2 Orality

Literacy and orality continue to co-exist in Arab societies as literacy has until recently been confined to sectors of the urban population. Consequently, large hinterlands exist in which oral traditions contain the sum of communal knowledge (Altarqi and El-Solh, 1988). Female illiteracy is more pronounced in the Arab world and, as has been discussed above, rates of female illiteracy in Morocco and Yemen are high (World Education Forum, 2000; Shabaan, 1988, see 2.2). Nonetheless, the significance of the oral tradition may extend beyond illiterate groups. Accordingly, where storytelling is used among literate women as a means of establishing ties of social belonging it may also represent a form of legitimate knowledge for these groups.

The organisation of knowledge in oral traditions has been explored by Ong ([1964], 1995) who maintained that forms of expression in literary cultures such as generalised information, have been developed through practices of reading, re-reading and analysing texts. Conversely, within oral or residually-oral societies, knowledge was suggested to be mutable and as such, was understood to be learnt and re-learnt through processes of apprenticeship (Ong, 1995). While oral traditions were suggested to reflect established cultural values and beliefs in order to reflect the cost and time invested in apprenticeship, knowledge within the oral tradition was also understood to be moulded through the interactive context of storytelling (Ong, 1995). Within oral or residually-oral groups, the oral tradition may thus present an ideal medium within which to negotiate new cultural identities. Accordingly, within conditions of migration, Somali male migrants in London have been suggested to use the oral tradition as a means of reproducing homeland cultures (Olden, 1999). Social networks constructed through storytelling, were also used by Somali men to obtain work in London (Olden, 1999). Where Somali migrant women considered maternity information to provide them with a sounder basis for understanding their pregnancies, they nonetheless sought oral knowledge to confirm medical advice (Davies and Bath, 2002). They same study also reported that Somali migrant women used maternity storytelling to consolidate their social networks (Davies and Bath, 2002). Storytelling networks and the knowledge produced through these may represent a means of establishing cultural identity among Moroccan and Yemeni and Iraqi study participants. Where storytelling is used as a from of legitimate knowledge through which to understand embodiment, it may also determine attitudes to the literate organisation of maternity information (4.2.2; 4.2.3; 4.3.1; 4.5.2; 4.7; 6.2; 6.4; 6.5).

2.4.3 Contextualising Arab Women's Storytelling in the Family

The family represents the core of Arab social organisation in rural, urban and Bedouin patterns of living. As a largely self-regulating institution, the Arab family may be characterised by forced consensus that consolidates its hierarchic and patriarchal structures of power (Barakat, 1993). While the women of the family are charged with socialising children into religious and social affiliation, the authority of older women has been suggested to function to support that of the male head of the household (Barakat, 1993). As such, storytelling within the family may represent a normative practice that may serve to reproduce patriarchal relations of authority. A contrasting perception of the structure of the Arab family, however, focuses on its considerable extension into social, economic and national life. In common with work previously reviewed (see 1.6), this approach traces ways by which women may use the extension of the harām or domestic space to pursue political and economic activities. Accordingly, through the mediation of male stewards ostensibly appointed and controlled by the family, wealthy women in Cairo were able to continue to invest and profit from entrepreneurial activities despite the ban on women's participation on such activities contained in the Napoleonic legal code (Al-Sayyid Marsot, 1996). More generally, the location of older women at the heart of social networks that exist separately from men's social networks, contribute valuable information to support the political and economic decisions of the male head of the household. Senior women in privileged families also use their position to mediate for less, well-placed women in the family (Nelson, 1974). Such an understanding of the ways in which traditional family structures may be used by Arab women to extend their participation in social life, may also point to possible resistant uses of feminine storytelling within the family. Hence, given the significance of symbolic constructions of motherhood and given the salience of the oral tradition within these groups, the ways in which Arab Muslim women narrate their embodied maternal experiences in the family may construct themselves in novel and unexpected ways (4.7; 6.2; 6.7).

2.5 Discourses of patient autonomy and the uses of maternity information

Divergent streams within the study of maternity information reflect major differences in conceptions of the status of the individual and the body. Having been developed from an understanding of health care as a service within which consumer choice leads to satisfaction, studies of 'user needs', are discussed within this section. The first sub-section (2.5.1), explores how such research has emphasised the function of information in supporting

patients' acts of decision-making on treatments and on options for care. A further characteristic of this approach is discussed in relation to its use of psychological concepts of the control of uncertainty through the seeking of information. The second sub-section (2.5.2), traces an approach within UK maternity policy which seeks to devolve to patients responsibilities for decisions regarding their care and treatment. In the third sub-section (2.5.3), an approach that characterises the social and gendered contexts of communication is described. The final sub-section (2.5.4), explores studies of transcultural communication in NHS maternity services.

2.5.1 Consumer information studies and patient participation

In the course of the previous two decades, a consensus has been established among commentators around the desirability of patients' participation in making decisions on their medical care and treatment (Coulter, 1997; Lupton, 1997; Grace, 1994). Studies of the information sought by patients on their conditions have reflected a similar understanding that individuals seek to contribute to medical decisions on their care (Stewart, 1995; Biley, 1992; Brearley, 1990). Studies of the uses of maternity information have also reported a widespread desire for information on birth (Read and Garcia, 1989; Cartwright, 1979). Conversely, the paucity of maternity information provided has been suggested to represent a primary cause for women's dissatisfaction with experiences of using maternity care (Kirkham, 1993; Read and Garcia, 1989; Cartwright, 1979). Authors have also advocated the provision of maternity information to patients throughout pregnancy to support their contribution to medical decision-making (Porter and Macintyre, 1989; Green et al., 1988; Macintyre, 1982). Where such acts of decision-making had not been accommodated in the provision of care, consequences on women's self-perceptions were believed to follow. In this way, in a large scale survey of women's experiences of maternity care, Green et al. (1988), used an adapted psychological tool for measuring post-natal depression to explore women's perceptions of their, 'control,' of the experience of birth (Green et al. 1988: 5). The study concluded that insufficient information on expected events together with a perception of low involvement in decision-making within the hospital environment, contributed to women's perceptions of their loss of, 'control,' over their care (Green et al. 1988: 22).

Qualitative studies of the use of information within maternity services, have reflected a similar emphasis on the regulation of pregnant and birthing embodiment by women's individual agency. Accordingly, women have been understood to seek maternity information to address gaps in their knowledge with which to prepare for embodied changes during pregnancy (Read and Garcia 1989; Cartwright, 1979). Similarly, women were demonstrated

to seek information to imaginatively project into the various situations that may arise during pregnancy, labour and birth (Kirkam, 1993; Read and Garcia 1989, Cartwright, 1979). In order to explore this perception of maternity information, the study will focus on the relationship between its imagined uses and conceptions of individual agency among each group of study participants (4.4.3; 4.5.2; 4.6.1; 4.6.2; 5.2.1; 5.2.2; 6.2; 6.3; 6.4).

2.5.2 Patient 'empowerment' and the boundaries of medical responsibility

British maternity policy has reflected a similar perception of the benefits of patients' participation in decision-making as that which has informed research on the uses of maternity information. Accordingly, the report of the expert maternity group into communication in maternity services (Department of Health, 1993), recommended that women's choices of the place of birth, the nature and level of pain relief, and on the benefits of screening tests should be supported by the provision of specific maternity information. The construction of the *Midirs* component of the Electronic Library for Health has represented a further development in the provision of such information (Department of Health, 2002a; 2002b). This on-line resource provides a range of electronic leaflets that address changes and potential difficulties in pregnancy, birth and early motherhood. By pairing each patient information leaflet with that offered to health professionals, the resource appears to have been designed not only to support consultation with health professionals but also to encourage women to consult specialist knowledge themselves. Where the embodied patient was suggested to relate to the biomedical body through the indirect medium of maternity information (2.3.3), women may thus be invited to adopt the controlling perspective offered by biomedical knowledge in order to participate fully in decision-making.

Policies of devolving medical decisions to patients have nonetheless been criticised by commentators within medical institutions. Accordingly, a study of General Practitioners (GPs) conducted by a major medical school, reported concerns regarding the increased anxiety caused to the patients by more extensive disclosure of medical knowledge (Elwyn et al., 1999). The study concluded that further commitments to providing patients with knowledge of their conditions should not be undertaken in the absence of organisational strategies to address patients' experiences of uncertainty (Elwyn et al., 1999). Having questioned constructions of the patient as an individual agent who is empowered by medical knowledge, a recent study has suggested that psychological notions of control may offer a means by which medical institutions may withdraw from areas such as chronic diseases that are problematic to medicine (Salmon and Hall, 2003). Having reviewed studies of the patients' perceptions of coping with disease that are advocated by British medical

institutions, the authors suggested that such notions of, 'fighting,' and maintaining a positive outlook were perceived by patients to disallow their expressions of distress (Salmon and Hall, 2003 : 1970). More widely, this critique has called for further research into the health professionals' individual encounters with patients in over to trace the uses of discourses of patients' management of their embodied states (Salmon and Hall, 2003)[2]. The study will thus explore health professionals' conceptions of women's control of their experiences of maternity care as this may represent an appropriate relationship to maternity services (5.2.1; 5.2.2; 5.2.4; 5.3.1).

2.5.3 Situational Context and Communication

A second approach to exploring the uses of maternity information within institutional settings has drawn on wider understandings of the construction of identity and difference in communication. Accordingly, Kirham (1989), explored the relation of class and gender identities in determining information-giving practices. Having examined the interaction of midwives and women during labour, she suggested that midwives' practices of providing support to women derived from their perceptions of women's co-operation with them. Kirkham further suggested that such perceptions of co-operation rested on the degree to which midwives identified with the woman's social class (Kirkham, 1989). As such, where women were perceived as belonging to the working-class, either because they were young and unmarried or because they were unemployed, midwives perceived them to be incapable of using maternity information to support their care (Kirkham, 1989). In these conditions, midwives dismissed women's reports of suffering by comparing them unfavourably to levels of resilience perceived to be normal (Kirkham, 1989). Similarly, midwives were reported to substitute generalised reassurance for information sought by working-class women on their progress through labour (Kirkham, 1989). A further strategy of disengagement from working-class women used by midwives involved practices of blocking direct requests for information by directing the conversation away from women's concerns (Kirkham, 1989). Having offered a direct contrast to conceptions of the needs - and capacities - of working-class women, middle-class patients such as teachers, social workers and local government workers, were perceived to be capable of using information to co-operate with their care. Accordingly, women in these groups were provided with information and support during labour (Kirkam, 1989). Having considered the means by which middle-class women sought information, Kirkham also suggested that, through mocking their desire for information and through suggesting their infantile state of dependence on midwives, middle-class women conformed with midwives' perceptions of the relation of gender and power in the workplace (Kirkham, 1989). In requesting advice from obstetricians - who were mostly male - midwives were thus

reported to have used similar strategies of self-derision to place themselves in the institutional structure of authority (Kirkham, 1989).

The discussion of the exclusionary basis of justice provided above (2.3.2), demonstrated how European, working-class men were historically constructed as non-subjects through their lack of education. In this respect, their position was similar, but not identical, to that of European women and colonised men who were also conceived to be non-responsible and were thus excluded from the construction of the subject of the law. In order to trace how these legacies of representation may coalesce in maternity services, the study will explore how health professionals' representations of class and education may determine perceptions of the rights of Arab Muslim women within this public sphere (5.2.2; 5.2.3; 5.3.1; 5.6; 6.3; 6.4).

2.5.4 Patterns in transcultural communication in maternity services

Research on women's experiences of birth in Britain conducted for the Expert Maternity Group reported more acute concerns with communication in maternity services among Black and minority ethnic women than those among White, British groups (MORI, 1993; McCourt and Pierce, 2000). This disparity in women's perceptions of the important of their relationship with the midwife has been suggested to have arisen from the perception of women from Black and minority ethnic groups that midwives within hospital maternity settings are unresponsive to their needs (McCourt and Pierce, 2000).

Non-English speaking women face considerable difficulties in seeking and using maternity information (Davies and Bath, 2002; Bariso, 1997; Bernard-Jones, 1992). Where non-English speaking women who give birth in NHS maternity services are not able to communicate with health professionals, they experience a profound sense of vulnerability. Having suggested the disorientating effects of the loss of communication during birth, a case study of non-English speaking Somali women described their fears for the safety of the child and reported their lack of confidence in the health professionals providing their care (Harper-Bulman and McCourt, 1997). Similarly, a study of Somali women reported that health professionals did not adequately explain invasive procedures to non-English speaking women (Davies and Bath, 2001).

A factor that may hinder communication with health professionals for women from minority ethnic groups, and that may be particularly pertinent for non-English speaking women, has been suggested by studies of uses of negative racial stereotypes by health professionals[3]. Negative typologies used to characterise Pakistani migrant women concern perceptions of

their unwillingness – or inability – to regulate their fertility (Woollett and Dosanjh-Matwala, 1990). An associated characterisation of migrant Somali women related to their purported abuse of NHS maternity care (Davies and Bath, 2001). Implicit stereotypes may also relate to the tolerance of pain among South Asian women, whose displays of suffering may be perceived as being culturally constructed – and hence perceived to be exaggerated. Conversely, Afro-Caribbean women's experiences of pain may be perceived to be culturally atypical and may thus be dismissed as being unfounded (Bowler, 1993). Health professionals may also perceive women who are not fluent in English to be too compliant or too exacting where they attempt to seek information and support during labour (Bowler, 1993). In such cases, health professionals may draw on other stereotypes such as that of the abuse of public services, or those of the limited intelligence of working-class women in order to justify withdrawing from communication with the woman whose request they have found inappropriate (Bowes and Domokos, 1996; Kirkham, 1989). Racial stereotypes used by midwives to determine the care that women from Black and minority ethnic groups want, need and deserve, inevitably condition communication with women from these groups and determine the degree of support that is offered them (Bowler, 1993). In order to reflect the insights offered by this work into the discursive conditions of transcultural communication, this study will explore the various dimensions through which health professionals represent the needs and merits of Arab Muslim women (5.2.2; 5.2.3; 5.4.2; 5.4.3; 6.3).

2.6 Methodological limitations of previous studies

While studies of the communication in NHS maternity services that have been reviewed above provide an important base of knowledge on discriminatory practices in the information-giving encounter, the methodologies used within these studies have notable limitations. These are described below as they were addressed in the design of this study.

Translation and Interpretation

Ambiguities associated with translation have implications for all studies that are conducted in a language in which the researcher is not fluent. Davies and Bath, (2002; 2001; 2000), conducted interviews in English and Somali with the aid of an interpreter. While audiotapes of the interviews were translated and transcribed by the interpreter prior to analysis, the veracity of interpretation was not quantified other than through the process of participant validation. In order to minimise the potential for misrepresenting participant responses, the transcripts of participants who spoke in Arabic were back-translated in the course of this

study. Accordingly, the English language transcripts of interviews in Arabic dialects were translated back into the original dialect by a second translator. The process will be further described below (3.2.4).

The construction and uses of maternity information

Studies of the use of maternity information among women from Black and minority ethnic groups have assumed that acts of decision-making contributed to patients' individual agency and autonomy and have understood that these effects were of primary importance to the women themselves (Davies and Bath 2002; Davies and Bath 2001; McCourt and Pierce, 2000; Bariso, 1997; Harper-Bulman and McCourt, 1997; Bernard-Jones, 1992). The model of the user of maternity services as an active agent who sought to affect decisions on her care was used to structure research questions and was deployed as a standard against which to measure observed practice (Davies and Bath 2002; Davies and Bath 2001; McCourt and Pierce, 2000; Bariso, 1997; Harper-Bulman and McCourt, 1997; Bernard-Jones, 1992). In order to explore individual and cultural differences in the use of maternity information, it will be necessary to move away from the conception of the user of maternity service that is configured around displays of autonomous, willed agency. Accordingly, having introduced the concept of legitimate knowledge of the body, the study will seek to trace how the uses of maternity information and storytelling, serve to construct cultural selves (4.6; 6.2; 6.5). Similarly through exploring the *proper* uses of maternity information within NHS maternity institutions, it will explore how the biomedical model of the body may contribute to these processes of identification along both main groups of study participants (4.6; 5.6; 6.3; 6.4).

The composition of migrant and minority groups

Members of migrant groups and many Black and minority ethnic groups, tend to occupy the same social and economic strata within British society and tend to experience similar barriers to NHS service provision. As such, studies of needs for health and social care that have included these groups have tended to ascribe to them a homogenous character (Mugerwa, 1997). Nonetheless, having emphasised shared experiences of social exclusion within and between these groups, such studies fail to address the cultural, political and social dimensions that influence uses of health services among these groups (McCourt and Pierce, 2000; Bariso, 1997; Harper-Bulman and McCourt, 1997; Bowler, 1993; Bernard-Jones, 1992). Having emphasised the low level of English spoken among these groups, many of these studies may also serve indirectly to blame migrant and minority ethnic groups for the exclusionary practices they suffer (McCourt and Pierce, 2000; Bariso, 1997; Harper-Bulman and McCourt, 1997; Bernard-Jones, 1992). Accordingly, this study has outlined the regional backgrounds of

Moroccan, Yemeni and Iraqi participants and will continue to emphasise differences in the uses and meanings of maternity information between each group (2.2; 3.2.1; 4.2.2; 4.7; 6.2; 6.4; 6.5). Individual characteristics of Moroccan, Yemeni and Iraqi participants will also be given in order to emphasise the range of individual subject positions from which they contributed to the study (3.4). Secondly, since the study does not assume that the primary function of maternity information for women is to support decision-making, it will move away from notions of women's English-language competence as a barrier to providing maternity information. Rather, it will explore how women's level of spoken English and health professionals' perceptions of these abilities intersect with other systems of producing British, Arab and Muslim cultures to project difference and produce identity in the information-giving encounter.

2.7 Conclusion and Research Questions

This chapter has expanded on the discussion of the natural-cultural body provided in the introductory chapter by exploring how knowledge used to establish embodied experience is implicated in patterns of authority and cultural belonging. Accordingly, it has introduced the concept of legitimate knowledge to denote knowledge of the body considered by participants to be culturally appropriate. Having outlined the social composition of the Moroccan, Yemeni and Iraqi participant groups in London, the chapter has also described the regions from which participants or their families had migrated. Diverse social backgrounds and differing experiences of literacy characterised the Moroccan, Yemeni and Iraqi study participants. These characteristics of the participant groups will be discussed further in the following chapter (3.5) and will provide a tool with which to explore the accounts of individual participants (4.1; 4.2.2; 4.7; 6.2; 6.5).

Conceptions of equity in British public services have been suggested to be structured by liberal theories of the Social Contract. The Social Contract understands that a just society is produced where individuals comply with universal reason in order to invest authority over themselves in the State. Where individuals act in this way they are considered to be responsible and are rewarded rights in society as subjects of the law. In order to obtain this status in society, individuals are understood to divest themselves of bodily desires and differences. Elements of legislative protection of Black and minority ethnic women in the NHS were suggested to relate to negative rights from discrimination. However, the rights of Black and minority ethnic women to equitable care and to give informed consent for interventions were suggested to rest on transcultural communication with health

professionals. While perceptions of identification and difference necessarily condition transcultural communication, where health professionals reference notions of the responsible individual to determine the rights of these groups, they may draw on the discriminatory basis of the Social Contract. While the model of the Social Contract presupposed that individuals could universally and systematically subdue their bodily and pre-social desires and could overcome their sense of embodied difference, failures to perform in this way were projected onto working men and onto women. Accordingly, non-property owning men were perceived to be unable to obtain an education and were thus understood to be prevented from developing the rational judgement necessary to enter into the Social Contract. While women were perceived as being free to enter the contract of marriage, they were also seen as failing act responsibly by divesting themselves of individual desires and as such were positioned within the private sphere to which rights did not extend. In contrast to the position of European women and the working-class, colonised men were constructed through their relation to their places of origin and were permanently seen to exist outside society. Health professionals may thus draw on complex legacies of representing Black and minority ethnic women through the private sphere, through their perceived lack of education or through their cultural or racial identifications. Each of these systems of representing the non-responsible status of these women, may be used to cast doubt on the basis on which they claim rights in the public sphere.

Maternity information may function as a form of legitimate knowledge by configuring the bodies of individual women according to cultural conceptions of a symbolic body. As the margins of the symbolic body - or society - have been suggested to represent sites on which the cultural difference of the group is enacted, so a model prison has been understood as an example of the manner in which societal power operates through surveillance. Through individuals' knowledge of their position as an object of vision, they were understood to internalise this perspective. Accordingly, scanned images were suggested to serve to invite women to take up an exteriorised position on their embodiment. Practices of providing information on potential hazards during pregnancy and birth were termed the, 'precautionary mode,' and the uses of such information that were approved by health professionals were termed institutionally *proper*. A study of historical British and French obstetric literature has illustrated how the feminine reproductive body was constructed to reflect the political organisation of society and the roles of obstetricians in it. Accordingly, maternity information would appear to serve as a form of legitimate knowledge through which to configure feminine embodiment as the object of a biomedical – and societal - perspective. Together with notions of feminine *discipline* discussed in the introductory chapter, women's practices

of using maternity information to survey their embodiment, may thus represent symbolic behaviours that reflect social organisation more widely.

Set against these suggestions of the cultural construction of maternity information, are philosophical and legal epistemologies that remain prevalent in much of the Muslim world. Within Islamic legal traditions and Muslim philosophy, visual representations have been indicated to be associated with corruption, sensuality and the heretical imitation of divine creation. Similarly, folk traditions in the Arabian peninsula associate visual images with malevolent powers. The status of visual images as sources of impurity and potential danger, may thus present important conditions for the use of maternity information in the form of visual images (4.5.3; 4.5.3; 6.2; 6.4). These conditions may also contribute to the prestige of oral storytelling as a form of legitimate knowledge among Arab Muslim women. Knowledge within oral societies has been suggested to reflect a cultural sanction against innovation. Nonetheless, as storytelling is constructed in specific contexts, it represents a particularly flexible medium for negotiating new patterns of cultural belonging in migration. Storytelling among male Somali migrants in London has served as a medium through which to establish social networks and to transpose homeland social contexts onto the conditions of settlement. Similarly, Somali women migrants have used storytelling to confirm maternity information and to consolidate social bonds with co-migrants. Accordingly, Moroccan, Yemeni and Iraqi participants may use their own maternity accounts as a medium through which to construct cultural selves in London. They may also draw on the accounts of other women to configure their maternal embodiment to symbolic understandings of the body and to resist the authority of maternity information and the model of the biomedical body on which it is based.

Studies of the provision and uses of maternity information by White, British women have adopted an understanding of the uses of information in decision-making that is founded on a perception that decision-making serves to establish individual agency. Having associated individual agency with the ability to project out of embodied states and to regulate embodied experiences of labour and birth, these studies endorse the perspective offered on the body by biomedical knowledge. Developments in NHS policy that reflect this association of decision-making with individual agency have been criticised by commentators who have noted that patients are emotionally ill-prepared to use information on their conditions to project into possible outcomes. Similarly, medical institutions and individual health professionals have been shown to draw on models of individuals' abilities to regulate their embodiment to withdraw from commitments to support patients suffering from incurable conditions, unexplained symptoms and from chronic pain. A study of communication in maternity

services that was conceived outside the model of the use of information in decision-making, explored midwives' uses of class and gender hierarchies in establishing perceptions of the appropriate use of information. Women from Black and minority ethnic groups were particularly aware of their interpersonal relationships with midwives and perceived these relationships to determine the information they receive. Non-English speaking, Somali women were not given sufficient information of their progress through labour and consequently feared for the safety of their children. Such fears were exacerbated by the limited confidence that these women had in the obstetricians and midwives providing their care. A further study reported that obstetricians did not adequately explain interventions to non-English speaking Somali women before these were performed on them. Studies of the interaction of midwives with South Asian and Afro-Caribbean women have suggested that negative stereotypes of women's capacities to tolerate pain were used by midwives to withhold communication from women in these groups. Midwives also perceived that South Asian and Somali women did not practice contraception and perceived that in having large families these groups sought to abuse the publicly-funded resources of the NHS. Since acts of decision-making have been suggested to serve to establish individual agency within the studies of women's use of information, women from Black and minority ethnic groups – and working-class women - appear to have been suggested to fail to attain the same status as subjects. Similarly, as midwives associated perceptions of the low prevalence of contraception among South Asian and Somali women with the abuse of maternity services, they also appear to have constructed these groups as having been non-responsible. Hence, defined by midwives through their cultural difference, and understood by midwives to fail to control the body, women from Black and minority ethnic groups may be perceived to have limited rights within NHS maternity services.

Maternity information may thus represent a form of legitimate knowledge of the body through which the body is understood by women and health professionals as the instrument of women's individual agency. Where health professionals perceive that groups of women fail to use maternity information accordingly, their merits to receive treatment in the public sphere of maternity services may be put in doubt. Oral storytelling has been suggested to represent a potential source of legitimate knowledge of the body among study participants. Where this to be used to understand maternal embodiment, rich potentials for imagining natural-cultural identities may be identified.

Notes to Chapter 2:

[1] Lists of questions on marital status, the number, location and dates of birth of children and broad markers of educational attainment were distributed to women prior to the interview and served to group the interview accounts during interpretation.

[2] The *Expert Patients Programme* proposed as part of the implementation of *Our Healthier Nation* (Stationery Office, 1998) provides an example of this practice of delegating medical responsibility to patients through discourses of empowerment. In launching the scheme, the Chief Medical Officer described how the scheme would contribute to the creation of:

'a new generation of patients who are empowered to take action with the health professional caring for them' Chief Medical Officer, 14th September, 2001.

Having suggested that experiences of 'coping' with chronic illness were more appropriately supported by patients than health professionals, the scheme envisaged using patients' own experiences to inform other sufferers of strategies they should undertake to manage their condition. In launching the scheme, the Chief Medical Officer also emphasised that patients using the scheme would: 'take more control of their own health' and suggested that they would thus learn to make better use of social services. The implications of the devolution of control to patients would then appear to involve greater compliance with medical advice while receiving less medical support.

[3] A considerable barrier for non-English speaking women in communicating with health professionals during labour is the difficulty of obtaining language support at night and during weekends (Davies and Bath, 2001). Following proposals relating to the, 'right' to communication contained in the NHS Plan (Secretary of State for Health, 2000), national structures have been put in place to ensure a continual language service through NHS Direct. Nonetheless, fears about misinterpretation and confidentiality may also limit the usefulness of interpreters (Davies and Bath, 2001).

Chapter 3:

Phenomenology and Narrative Research Methods

3.1 Introduction

This chapter will set out the methodological approach used to design the study. In describing the phenomenological approach to sensory experience, it will also consider how this approach was combined with an understanding of the narrative configuration of identity in participants' accounts of the body and of the knowledge that was used to understand it. The second section (3.2), will describe the narrative methods used throughout the study. Within this section, the recruitment of the participant groups and the salient characteristics of study participants will be described. The same section will outline how material was gathered using methodological - and data - triangulation. The following section (3.3), will review the model of the lived body that has been discussed in the introductory chapter (1.4), and will describe how the ambiguous status of language in phenomenology was addressed by the study. An overview of the methodological approach taken will explain the means by which narrative and phenomenological approaches were combined. The fourth section (3.4), will introduce the narrative inquiry methodology adopted to interpret and represent interview accounts. Examples of interpretation will be provided in order to demonstrate the function of each narrative focus in identifying the construction of legitimate maternity knowledge. In order to emphasise the positions from which Moroccan, Yemeni and Iraqi participants narrated their accounts, false names and biographical sketches will be used to introduce the accounts of women from these groups. Steps taken to derive themes across accounts and interviews will be described in relation to the deployment of a limited structuralist approach, outlined in the introductory chapter. This approach will be described in terms of its function of examining the relations of latent conceptual oppositions in forming cultural frameworks within which

symbolic bodies were imagined. The fifth section (3.5), will delineate the ethical latitudes of the study. Problematic areas surrounding the collection of the study data will be examined in the following section (3.6), as these were addressed during the interpretation of the accounts. The final section (3.7), will summarise the salient points of the discussion.

3.2 Methods

This section provides an overview of the methods used to recruit and interview participants and to validate the study data. The first sub-section (3.2.1), recounts how exploratory focus groups and semi-structured interviews were combined in the study and describes how the narrative approach was integrated throughout the research process. It discusses the regions and localities from which participants or their families had migrated and provides details of the characteristics of each study participant. It also outlines the process of interviewing and discusses the dates, duration and locations of interviews Within the second sub-section (3.2.2), practices of triangulation and participant validation undertaken in the study are set out, while the construction of composite accounts are discussed in the third sub-section (3.2.3). The final sub-section (3.2.4), delineates practices of back-translation that were undertaken in the study.

3.2.1 Overview of methods used

The project used exploratory focus groups and semi-structured interviews with a total of 44 Moroccan, Yemeni and Iraqi participants. Focus groups were conducted 22 participants from this group - 6 of these having been Iraqis, 10 Moroccan, and 6 Yemeni. Broad themes produced from the transcripts of these focus groups were used to develop interview guides that were used in individual interview (see appendices i, ii). Differences in the approaches related to a greater emphasis on the kind of information provided and that sought. A further aspect of the approach to individual interviews that was suggested through the focus group interviews related to perceptions of health professionals and their possible views of the participant groups.

The study sought to explore ways in which cultural perceptions of knowledge, agency and the female reproductive body entered the reported professional practices of health professionals. Accordingly, as focus groups tend to invite a consensus on the issues discussed, no focus group interviews were conducted with these groups (Sarantakos, 1998).

Individual interviews were conducted with Arab Muslim (N = 23), participants who, with the exception of one participant (M1; MFG2, see 3.6), did not participate in the focus group interviews. This group was comprised of Iraqis (N = 6), Moroccans (N = 10), and Yemenis (N = 7). All adhered to Sunni Islam. The narrative approach was integrated throughout the study. Accordingly, prompts given in interviews were composed of reconstructed stories. Participant narratives provided the research data with narrative methods also having been used to interpret the accounts and to identify patterns across accounts and between participant transcripts. Validation was undertaken using stories reconstructed from the interview accounts, while the study findings reported in Chapters 4 and 5 will be comprised of participant accounts.

Codes were used to protect the privacy of participants (see 3.4; 3.5). These also relate to the place of the story in the sequence of accounts provided during a single interview. As such, M1.4, referred to the fourth story given by the first Moroccan participant and had no relation to story M2.5. In the case of accounts provided in the exploratory focus group interviews with Iraqi, Yemeni and Moroccan groups, the code for the narrator is given after that of the story. Hence, YFG.4.1 refers to the fourth story given in the Yemeni group interview, the extract having been narrated by the first participant.

Sampling and recruitment

A purposive approach was used to recruit groups of participants to the study who had certain predefined characteristics in common (Denscombe, 1998). Those selected were Arab Muslim women living in London who had used maternity and women's health services in the city during the previous ten years. Despite this criterion – which was expanded considerably from that initially used - women belonging to an older generation interviewed within the Moroccan sample (M2; M4), were the mothers of second families due to widowhood and divorce. Among this group one had an elder daughter who also participated (M3 and M4).

Women belonging to Iraqi, Moroccan and Yemeni communities formed the sample due to the willingness of organisations representing these groups, to support the study. Initially, there was no intention of focussing on these communities, nonetheless the widely varying relationships to homelands and family homelands that emerged from the material have suggested that the composition of the sample was a fortuitous accident (2.2; Chapter 4).

Communities

The Moroccan group consisted of migrant and second-generation women. While four women in this group had migrated as adults (MFG1; MFG3; MFG7; M2 and M4), ten participants belonging to the second-generation (MFG4; MFG5; MFG6; MFG8; MFG10; M5; M6; M7; M9; M10). Three participants who had migrated from Morocco as children were also interviewed (M1/MFG2; M3; M8). Participants in these groups had migrated from the Rif mountains in central Morocco (M2; M3; MFG1; MFG7), and from the Anti-Atlas mountains (MFG3; M8). These regions support a pastoral economy as will be suggested in the discussion of participants' accounts (2.2; 4.2.2; 4.7; 6.5). A further group of participants had migrated from the arable farming district of Agadir (M1/MFG2; M4). The families of second-generation participants had migrated from the Rif mountains (MFG4; MFG8; MFG10; M7), and from the Anti-Atlas mountains (MFG5; MFG6; M5; M6; M9; M10). Across the Moroccan groups, a number of participants maintained ties with these regions by spending holidays there with their children (M1/MFG2; MFG8; M5; M7; M8; M9; M10). In the case of one participant, the family home had passed out of the family and the family would stay with cousins (M8, see 4.2.2; 6.2). As such, visits to regions of origin in Morocco may indicate wider patterns of identification rather than suggesting participants' family obligations.

Yemeni and Iraqi groups included only migrant participants. All Iraqi participants were from Baghdad with the exception of one (I2), who had lived in Mosul prior to migrating to London but who was raised in Baghdad. Iraqi participants who gave details of their neighbourhoods in Baghdad had originally lived in the residential districts of Al-Mansur (I1; I3; IFG2), Al-Rashid (I4; I5; I2), and Al-Qadisya (I6; IFG.1; IFG4; IFG5; IFG6), in the Central West section of the city and in the South Western suburbs. Yemeni participants had migrated from the Northern administrative district of Sa'dah (Y1; Y3; Y4; YFG2; YFG4; YFG6), where the economy is pastoral (2.2; 4.2.2; 4.7; 6.5). Others had migrated from the city and region of San'a (Y2; Y5; Y6; Y7). Among this group, two participants (Y6; Y7), suggested they had previously migrated from rural areas. A further group did not mention the localities from which they had migrated (YFG3; YFG5), however all participants were from the North of Yemen.

Arab Muslim Participants' Individual Characteristics

Participants across interviews were grouped into three age groups, these consisting of participants aged under thirty years old, under forty years old and under fifty. Within these groups, four Moroccan, two Yemeni and three Iraqi focus groups participants were aged under thirty (these being participants: MFG6; MFG8; MFG9; YFG1; YFG4; IFG4; IFG5 and IFG6). The group aged under forty years consisted of four Moroccan, three Yemeni and three Iraqi participants (these being participants: MFG2; MFG3; MFG4; MFG5; YFG2; YFG4; YFG5; IFG1; IFG2 and IFG3). The group aged under fifty years was comprised of three Moroccan, two Yemeni, and no Iraqi participants (these being: MFG1; MFG7; MFG10; YFG3 andYFG6). Within the groups individually interviewed, five Moroccan, two Yemeni and three Iraqi participants were under thirty (these being participants M4; M7; M5; M9; M10; Y4; Y6; I1; I4 and I6). Four Moroccan, four Yemeni and two Iraqi participants were ages under forty years (these being participants M1; M3; M8; M6; Y2; Y3; Y5; Y7; I2; I3). One participant in each national group was aged under fifty years (participants M2; Y1 and I6). Half of the Iraqi focus group participants (IFG1; IFG2; IFG3), had received graduate level education, while half (IFG4; IFG5; IFG6), had received secondary education. Among participants in individual interviews, three (I2; I3; I4) had received graduate level education, three had secondary level education (I1; I5; I6). Within the Moroccan group, three focus group participants had education up to graduate level (MFG3; MFG4; MFG5), five participants had received secondary education (MFG2; MFG6; MFG8; MFG9; MFG10), while two had received only primary school education (MFG7; MFG1). Two Moroccan participants in individual interviews had graduate-level education (M8; M10), while the corresponding figure for secondary level education was six (M1; M3; M5; M6; M7; M9). One participant reported she has no education (M2), and no information was given by another (M4). Among Yemeni participants in the focus group, three participants had received primary education (YFG1; YFG4; YFG5), while three (YFG2; YFG3 and YFG6), had received secondary education. Two participants in individual interviews had graduate level education (Y2 and Y5), and two participants had received secondary education (Y6 and Y4). Three participants had received primary school education (Y1; Y3; Y7). Non-English speaking women were concentrated in the Yemeni group (Y1; Y2; Y3; Y4; Y6 and Y7). Nonetheless, participants in other groups preferred to be interviewed in Arabic (I2; I3; I5 and I6 and M3; M4; M6; M7 and M8[1]). Some participants in focus groups (YFG1; YFG 2; YFG3; MFG1 and MFG4), contributed in Arabic while others (IFG4 and IFG6), contributed in Arabic and English.

Participant characteristics are given in a tabulated form below.

Participant code	Age	Migration Status	Education	Language
MFG1	Under 50	Migrant	primary	Arabic
MFG2	Under 40	Migrant (early)	secondary	English
MFG3	Under 40	Migrant	graduate	English
MFG4	Under 40	2nd generation	graduate	Arabic
MFG5	Under 40	2nd generation	graduate	English
MFG6	Under 30	2nd generation	secondary	English
MFG7	Under 50	Migrant	primary	English
MFG8	Under 30	2nd generation	secondary	English
MFG9	Under 30	2nd generation	secondary	English
MFG10	Under 50	2nd generation	secondary	English
M1	Under 40	Migrant (early)	secondary	English
M2	Under 50	Migrant	none	English
M3	Under 40	Migrant (early)	secondary	Arabic
M4	Under 30	Migrant	No information	Arabic
M5	Under 40	2nd generation	secondary	English
M6	Under 40	2nd generation	secondary	Arabic
M7	Under 30	2nd generation	secondary	Arabic
M8	Under 30	Migrant (early)	graduate	Arabic
M9	Under 30	2nd generation	secondary	English
M10	Under 30	2nd generation	graduate	English
YFG1	Under 30	Migrant	primary	Arabic
YFG2	Under 40	Migrant	secondary	Arabic
YFG3	Under 50	Migrant	secondary	Arabic
YFG4	Under 30	Migrant	primary	English
YFG5	Under 40	Migrant	primary	English
YFG6	Under 50	Migrant	secondary	English
Y1	Under 50	Migrant	primary	Arabic
Y2	Under 40	Migrant	graduate	Arabic
Y3	Under 40	Migrant	primary	Arabic
Y4	Under 30	Migrant	secondary	Arabic
Y5	Under 40	Migrant	graduate	English
Y6	Under 30	Migrant	secondary	Arabic
Y7	Under 40	Migrant	primary	Arabic
IFG1	Under 40	Migrant	graduate	English
IFG2	Under 40	Migrant	graduate	English
IFG3	Under 40	Migrant	graduate	English
IFG4	Under 40	Migrant	secondary	Both
IFG5	Under 30	Migrant	secondary	English
IFG6	Under 30	Migrant	secondary	Both
I1	Under 30	Migrant	secondary	Arabic
I2	Under 40	Migrant	graduate	English
I3	Under 40	Migrant	graduate	Arabic
I4	Under 30	Migrant	secondary	Arabic
I5	Under 30	Migrant	secondary	Arabic
I6	Under 50	Migrant	graduate	English

Table of the characteristics of Moroccan, Yemeni and Iraqi participants

Interviews with Arab Muslim Participants

Locations used by the Yemeni and Moroccan community associations in Central and West London (Edgware Road and Portobello), were used to conduct the focus group interviews. The Iraqi focus group interview was conducted in a family house in Surrey. Focus groups interviews were conducted between the 5th of February and the 30th of March 2002. Each of these took around an hour and a half. Interviews with individual participants in the Yemeni group were conducted in the women's own homes and in a community building. In the case of the Iraqi group, these took place in a Qu'rān - ic school. In the case of the Moroccan

group, participants were interviewed at two specially organised women's parties. The festive atmosphere that surrounded these interviews, appears to have prompted participants to provide expansive and detailed accounts. Similarly rich accounts were provided by Iraqi participants in individual interviews. In contrast, possibly due to the larger proportion of non-English speaking participants in this group, accounts provided by Yemeni participants were less developed. The effects of these differences will be addressed in the discussion on the limitations of the methodology provided below (3.6). Interviews with each group varied in length between fifty minutes and an hour and a half. All individual interviews were performed during an eight-month period between the 10th March and the 10th of November 2002. No man was present during any of the interviews with Moroccan, Yemeni and Iraqi participants (3.6). In accordance with ethical responsibilities, codes were used to identify each participant (3.5).

Health Professional Participants

Health professional participants groups were composed of GPs (N = 4), midwives (N = 4), and obstetricians (N = 5). Each of these participants was based in West London and had provided maternity care to Arab Muslim women in London in the previous two years. Purposive and snowball sampling approaches were used to recruit these groups with contact having been made with a major maternity hospital in West London that serves a large Arab population. General practitioners serving the same West London areas were recommended by the first participant in this group. The sample was mostly composed of women health professionals, with only one male health professional having been interviewed in each group (OBS4; GP3; MD3). Among the women interviewed, four (GP1; GP2; OBS2; MD2), had a child or children. The male general practitioner (GP4), suggested he had children but reported on the questionnaire that he was childless. The majority of participants (N = 7), had qualified between 1982 and 1992 (GP1; GP2; GP3; GP4; OBS2; MD1 and MD3). A smaller group, mainly composed of obstetricians, had qualified between 1992 and 2002 (OBS1; OBS3; OBS4; OBS5 and MD4), with one participant having qualified around 1972 (MD2). The largest group of participants was White and English (OBS1; OBS2; GP1; GP2 and GP3). Two participants described themselves as Indian (OBS5 and MD3), and two described themselves as Irish (OBS4 and MD4). One participant described herself as Jamaican (MD2), while further participants described themselves as: Black English (MD1), Black African (OBS3) and Spanish (GP4). In terms of their religious affiliations, the largest group of participants were Catholics (OBS4; GP4; GP1; MD1; MD4), and Hindus (OBS5; MD3). Other participants described themselves as: Christian (OBS2), Anglican (OBS1), lapsed Catholics (GP2), lapsed Anglican (GP3), and Muslim (MD2). A final participant reported

having no religious affiliation (OBS3). A table that displays these characteristics is provided below.

Participant Code	Gender	Children	Period since qualification	Ethnic group (Self-described)	Religious affiliation (Self-described)
GP1	Female	Yes	10 – 20 years	White, English	Catholic
GP2	Female	Yes	10 – 20 years	White, English	Lapsed Catholic
GP3	Female	No	10 – 20 years	White, English	Lapsed Anglican
GP4	Male	Unclear	10 – 20 years	Spanish	Catholic
Obs1	Female	No	Less than 10 years	White, English	Anglican
Obs2	Female	Yes	10 – 20 years	White, English	Christian
Obs3	Female	No	Less than 10 years	Black African	None
Obs4	Male	No	Less than 10 years	Irish	Catholic
Obs5	Female	No	Less than 10 years	Indian	Hindu
MD1	Female	No	10 – 20 years	Black English	Catholic
MD2	Female	Yes	30 years	Jamaican	Muslim
MD3	Male	No	10 – 20 years	Indian	Hindu
MD4	Female	No	Less than 10 years	Irish	Catholic

Table of the individual characteristics of health professional participants

The interview encounter with health professional participants was structured around four sets of questions which served as prompts for participants' accounts (3.2.2, see appendix iii). Individual, semi-structured interviews with general practitioners were conducted between 6th September and the 24th October, 2002 in four medical practices in West London. Each of these interviews took around an hour. Interviews with midwives were conducted in the birth centre and antenatal clinics of the large maternity hospital in West London where the midwife contact was employed. Interviews with obstetricians were conducted in a rest room while the participant was on-call. Interviews with both groups were conducted between 6th and 15th of November, 2002 and varied in length between fifty minutes and an hour and a half. The longer interviews were conducted with female obstetricians (OBS1; OBS2; OBS3). The possible bias introduced into the data by the varying length of the interview and the nature of the accounts produced will be addressed below together with the discussion of the uneven quality of accounts produced by Moroccan, Yemeni and Iraqi participants (3.6).

3.2.2 Triangulation

Given that the study aimed to represent meanings attached to motherhood and information/knowledge within individual narratives while also attending to the cultural framework suggested by these accounts, it sought to trace patterns across narratives and between individual participants. Accordingly, the common features of participants' accounts

were established using methodological - and data - triangulation (Sarantakos, 1998). Methodological triangulation involved the combination of accounts drawn from the focus groups with those recounted during individual interviews in order to identify common patterns and differences that occurred across these public and private interview encounters (see 1.6; 3.7). Data triangulation involved referencing data across individual interviews. An example of this method is provided by the recurrent uses of variants of the adage, 'everyone's labour is different' in women's narratives (M1.2; M6.6; Y6.5; Y7.2; I6.5; I5.1; IFG.1). This was used to protest against generalisations in other women's accounts. However, it was also deployed by other participants to invalidate the claims of medical information. A final use of the adage proceeded accounts of the speaker's own experiences of labour and birth and was deployed to counter the listener's possible reservations concerning the relevance of these accounts. Similarly, in the case of health professionals, the simile of natural labour as a race for which prizes would be awarded (GP4.7; OBS2.4), was used to explain the necessity of providing information on pain relief to women or was used to explain women's reluctance to consent to interventions during labour.

3.2.3 The construction and use of stories as study materials

In providing an emotionally immediate context for discussions, narratives reconstructed from a number of sources have the advantage of offering more concise accounts than actual reported narratives (Morgan 1997). Having incorporated direct speech, common phrases and repetition, the reconstructed stories that were used within this study provided a valuable means of reproducing informal discourse on maternity. Accounts thus produced related more directly to maternity storytelling among Arab Muslim women and served to reproduce the inter-personal dimensions of the information-giving encounter between both main participant groups.

Reconstructed stories as prompts

Reconstructed stories that combined published work on maternity care and fragments of accounts given informally to the researcher were used to prompt women's accounts during focus groups and individual interviews (Papadopoulos, Scanlon and Lees, 2001). As such, the moderator's guide to the exploratory focus groups included reconstituted stories that sought to illustrate individual patterns in the use of maternity knowledge in medical decision making and sought to explore women's preferred sources of maternity knowledge (appendix i). Further stories engaged with understandings of motherhood and sought to prompt participants to consider how their uses of maternity knowledge served to conform with - or to challenge - cultural constructions of motherhood. The first reconstructed story used in

individual interviews with Iraqi, Moroccan and Yemeni participants incorporated a comment published in a well known work advocating natural birth (Savage, 1986). This account appeared to confuse women's displays of individual agency through seeking maternity information with a normative understanding of virtuous motherhood. Having been drawn from a similar source (Flint, 1986), the second account represented acts of seeking maternity information for decision-making as a maternal duty. The third and final account was drawn from material obtained during the researcher's previous work. This described how a Somali woman used knowledge previously obtained from friends to determine whether the possible dangers to her foetus that were described by health professionals necessitated an emergency intervention in labour. Accounts were followed by direct questions relating to the context in which they arose. The final section of the interview guide consisted of open-ended prompts concerning the meanings of motherhood and the purposes of personal narratives of pregnancy and birth. Nonetheless, reconstituted stories formed the core of approach to interviews with Iraqi, Moroccan and Yemeni groups (appendix ii).

Health professional participants appeared to feel constricted by the range of themes brought up in the reconstituted accounts. Where the approach was most more successful health professional participants related to the accounts by analysing the style of composition. A degree of frustration was expressed in the case of the participants (GP1; MD1) who were interviewed using this method as both found it easier to generalise from their experiences. Given the stilted nature of responses elicited using this method, the method was abandoned in favour of an explanation of the narrative approach. Four sets of questions that broadly reflected the themes of the stories replaced the narratives within the interview guide (see above, 3.2.1). Broad-ranging questions on the construction and use of maternity information at particular points during pregnancy were asked at the beginning of the interview. These were followed with questions of the perceived information needs of women and alternative sources of maternity information that might be used. The closing section of the interview guide explored perceptions of the cultural meanings of motherhood and the practice of storytelling among the participants own peers. Exceptions to this approach were made in the case of interviews with two male health professionals (GP4; OBS4). As these participants initially provided accounts of insufficient length and complexity, many more questions were asked to draw out details of their information-giving practices and to elicit accounts of the appropriate uses of the information they provided.

A short list of questions was used to collect the basic demographic data from both sets of participants that is reported above [2].

Validation Stories

Participant validation involves soliciting the views of study participants on the findings produced (Sarantakos, 1998). This method was deployed among each of the participants groups. Given the narrative understanding of subjectivity informing the study, however the primary function of validation was to invite participants to examine the representation of their accounts in the light of their subsequent self-understanding. Accordingly, participants were invited to re-author the accounts if they were unsatisfied. As has been advocated by Papadopoulos, Scanlon and Lees (2001), during the final stage of analysis, validation stories were reconstructed from patterns across a transcript and from words and phrases that were repeated within it or that had represented an important aspect of its interpretation (appendix iv). These were sent to one member of each Arab Muslim participant group and to one of each of the health professional participant groups. Validating interpretations of particular words and phrases was particularly important as some linguistic features were used to interpret the themes and content of accounts. For this reason, phrases used in interpretation were also incorporated in the stories. An explanatory letter accompanying the validation stories described how the accounts had been constructed. An individual validation form identified themes and issues of self representation within each reconstructed account and invited participants to correct any aspects that they felt were misrepresentative. Spaces for correcting omissions or for adding further content were also provided on the form that was enclosed with the validation stories (appendix v).

3.2.4 Translation transcription and interpretation

In accordance with recommendations made in Papadopoulos and Lees (2002), all material was discussed at length with an interpreter. Where the material would be used in its written form, in publicity leaflets and in transcripts, it was back-translated into English by a second translator. This step was undertaken in order to identify ambiguities within the translated material and to identify and to address culturally specific concepts. Interview materials were also discussed at length with interpreters from all three Arab Muslim participants groups. Nonetheless, since the medium of the interview was oral, no written translation was produced. These extended discussions with interpreters also served to ensure that the expression of key questions was agreed between the interpreters and by the researcher. Accordingly, when the interpreter departed from the written guide to speak in dialect, the sense of the questions was set within parameters that had previously been defined.

In order to produce transcripts of interviews with Iraqi, Yemeni and Moroccan participants, audio tapes of interviews conducted with an interpreter from the relevant group were translated by the same interpreter and were transcribed by her. Additionally, in order to validate the translation, a transcript in Arabic was also produced in each case and was then translated into English by another individual belonging to the same organisation and belonging to the same national group.

Important issues surrounding the status of spoken Arabic were identified through this process, since in the cases of both Iraqi and Yemeni groups, the transcripts produced neither corresponded with each other nor corresponded to the dialect spoken on the tape. Both sets of interpreters considered their dialect to have been entirely oral. Hence, the interpreters had assumed that their dialects had an approximate relationship to standard Arabic but had perceived that these dialects did not have a direct written equivalent. Standard Arabic is a powerful administrative language and as such, interpreters may also have believed that a more authoritative account of the discussions might be produced through this medium (Anderson, 1983). In addition, much of the specific discussion on bodily experiences and perceptions was approximated in these summaries – a practice of eliding the female body that will further be discussed in relation to Iraqi participants (4.4.3; 4.6.2; 4.7; 6.2; 6.4; 6.5), and to health professionals (5.2.3; 5.4.1; 6.3; 6.4). Since the interpreters had been unfamiliar with the usual system of representing dialect speech, a second dialect transcript was produced in all cases where participants had spoken in dialect. Some anomalies persist and are believed to have reflected a syncretic use of standard Arabic where no dialect equivalent for medical terms was readily available.

3.3 Phenomenology and the Narrative Self

This section reviews phenomenological understandings of the relation of lived experience and culture and introduces narrative inquiry methods that explore the individual means by which lived experience is established in language. The first sub-section (3.3.1), addresses the ambiguous status of language within model of the natural-cultural body that was discussed in the introductory chapter (1.4). Narrative inquiry methodologies are discussed as these understand experience to be ordered and to be ascribed meaning in language (3.3.2). Finally, the section will provide an outline of the methods by which narrative and phenomenological approaches were combined in this study (3.3.3).

3.3.1 Phenomenology - The Self in the Body

As has been discussed in the introductory chapter, the model of the natural-cultural body that has been developed from the work of Merleau-Ponty has provided a means by which to trace the relationship of individual feminine embodiment and cultural representations of the feminine and maternal body. Nonetheless, this relationship has been problematic due to the ambiguous status of language within the model of the body in early phenomenology and in the early work of Merleau-Ponty. While Merleau-Ponty himself critiqued his early work for its assumption that a pre-cultural and pre-linguistic self was retrievable, having located the embodied self in a web of multiple relations with the world, the early work may also accommodate a narrative understanding of identity. Hence, as Merleau-Ponty later stated that embodiment was understood by individuals through language, acts of narrating experience may be seen to provide the medium within which natural-cultural selves are produced. In this way, through exploring individual strategies of narrating embodied experience, the relations between natural-cultural bodies and their symbolic equivalents will be traced.

3.3.2 Narrative Inquiry Methodology

In common with the understanding of the narrative self proposed by Ricoeur, narrative inquiry approaches maintain that individuals understand and create their selves by recounting their experiences. Accordingly, narrative inquiry explores the means by which personal agency may recast a natural-cultural self by exploring how individual experience is imaginatively transformed within the narrative form. An example that explores transnational identities using this approach, has been provided above (1.5.3). In their study of the biographical account of a Turkish woman migrant in Germany, Inowlocki and Lutz (2000), illustrated how the woman negotiated and expanded the representative categories imposed on her group. Accordingly, she was shown to have contested the category of the, 'uncivilized [sic] stranger,' by demonstrating the barbarity of the German system of labour recruitment and by the burlesquing the humiliations that she initially suffered in Germany (Inowlocki and Lutz, 2000: 308 - 310). By focusing on her relationship with her mother to describe her marriage and divorce, the woman presented the discourse of honour as an intergenerational issue that was founded on women's relationships with each other (Inowlocki and Lutz, 2000: 310 - 311). Similarly having explored her use of humour and having considered her structuring of the narrative around a series of encounters with Germans and Turks, the authors concluded that she had recast the experiences of loss or being, 'twice rootless', through appealing to the concept of mélange (Inowinski and Lutz, 2000: 311 – 312, 314 - 315). Thus the woman's life story was reconfigured around a thread of personal agency that ran through each of the events. This thread of agency was traced through the accounts of her

migration to her position as the narrator of the account who determined her own ways of belonging to Turkey and Germany.

3.3.3 Overview of the methodological framework

The approach taken to planning the study drew on the understanding of the inter-relation of language, culture and embodiment and combined this with a perception of the role of interaction with cultural difference in forming individual and collective identities. An additional element of the approach related to the conception of legitimate knowledge of the body as the means by which individual embodied experience was invested with symbolic meanings within participants' accounts. Hence, by exploring narratives of the appropriate use of knowledge to endow individual embodied states with symbolic meanings, the production of individual cultural selves was traced in relation to multiple dimensions of belonging and difference. Conversely, patterns across participant accounts were considered in order to characterise common aspects of the construction of legitimate knowledge and of the perception of symbolic bodies that served to indicate participants' social belonging.

3.4 Narrative Interpretation and Representation

This section outlines the means by which the narrative approach was integrated into the interpretation and representation of participants' accounts. The first sub-section (3.4.1), introduces the schematisation of narrative analysis used in the study. In order to illustrate how each focus of interpretation served to reveal different dimensions of participants' construction of embodied and cultural selves, examples from their accounts are discussed within the remaining sub-sections. Accordingly, in the following sub-section (3.4.2), the situational nature of the interview and issues of research reflexivity are described through exploring aspects of participants' accounts. Narrative strategies through which participants represented their positions in relation to the events they recounted are outlined within the third sub-section (3.4.3). Similarly, the fourth sub-section (3.4.4), explores features of participants' delivery of accounts as these served to signal their identifications within the interview encounter or with groups or discourses outside it. Participants' uses of metaphors are also considered as they served to recast their experience in relation to wider discourses of belonging. Finally, the section outlines how the narrative strategies used by individual participants were related across their accounts (3.4.5).

In reading the discussion of the study findings in the following chapters, the large size of the Moroccan, Yemeni and Iraqi participant groups relative to that of the health professional

participants, may lead the reader to lose a sense of the individual characteristics of these participants. In order to suggest the personal histories that Moroccan, Yemeni and Iraqi participants brought to the interview, false names and a brief biographical sketch will be given to introduce the elements of their accounts that are discussed here. Codes and brief demographic data will be used to introduce the accounts of health professional participants.

3.4.1 Narrative Interpretation

Since Narrative Inquiry is an interpretative approach that emphasises the individual context of accounts in which accounts are performed it has not developed a uniform cycle of analysis to guide procedures through the research process. While criticism has been levelled at the perceived indeterminacy of this approach, broad methodological parameters have begun to be set. An account of research methods provided by McCormack (2000a, 2000b), was of particular interest to this study as it sought to relate linguistic and contextual dimensions of storytelling to their content. McCormack described the use of multiple perspectives – or 'lenses' - that investigate transcripts as narrative productions (McCormack, 2000a: 282). Interpretative, 'lenses' were used to located the performance of accounts within the context of the interview and within the social and cultural context in which the interview encounter was held (McCormack, 2000a). McCormack described five interpretative 'lenses', these being, active listening; context; research position; narrative processes; language and moments of change or reflection (McCormack, 2000a: 282 - 296). While these foci provide a valuable means to explore various dimensions of accounts, the schema proposed by McCormack conforms to a linear sequence of analysis. By distinguishing a number of separate steps of interpretation, the schema and appears to serve to divorce form, content, context and expression prior to reintegrating these elements in interpretative stories (McCormack, 2000b). As this study did not seek to separate the content of accounts from the contextual and formal dimensions of storytelling a number of the interpretative 'lenses', proposed by McCormack were collapsed in the methods used.

Occurring simultaneously, the stages of, 'active listening' to the audiotapes and the writing of notes on the, 'researcher position' and the, 'context' of the narration, provided a record of the interview interaction that was completed while the interview remained fresh in the researcher's mind. These notes on the contexts of the interview encounter represented a sound basis for further interpretation. During the two later stages the researcher referenced and revised her notes on the interview context in accordance with her emerging understandings of the content and the form of the participant's accounts. Having been related

to the content of accounts, the focus on, 'narrative processes' that includes instances of, 'augmentation and theorising' was used as suggested by McCormack. Nonetheless, an overall understanding of the content of participants' accounts was achieved by combining the focus on participants' expression of the events recalled (language) with that of, 'moments of change and reflection'.

3.4.2 Active Listening, Context and Researcher Position

As McCormack has suggested, 'active listening,' involves repeated listening to the interview tapes in order to establish the narrative structure of the accounts given and to in order to explore the researcher's reaction to the participant and to the account provided (McCormack, 2000a). The researcher thus considers the identities of the characters in the accounts together with the time and location of narrative events as they relate to the organisation of the narrative (McCormack, 2000a). This phase of interpretation culminates in the researcher's self-reflexive examination of the position taken in relation to the interview and in relation to the participant (McCormack, 2000a). Within this study, many weeks had often elapsed between performing the interview and listening to the tape. As such, this framework enabled the researcher to recall the accounts, her reactions to them and their performance. An example of the function of this first phase of interpretation in focussing on the organisation of the narrative and the researcher's position in relation to it, is provided by the account of Rachida, an early-migrant Moroccan participant (M8). Rachida had migrated from a village in the Anti-Atlas mountains when she was six years old. While the house where she grew up was no longer occupied by her family, she would regularly return to the region to stay with her cousins. Having received a graduate-level education, Rachida was married with two children and worked in local government (who were one and two years old at the time of the interview). She described how during labour, she was in too much pain to understand health professional interaction. Having continued to recount how she had insufficient knowledge to understand her progress, she recalled how her husband would, 'watch' the health professionals who gathered in the birthing room (M8.4). Having speculated that the health professionals, 'never thought he could hear or understand,' Rachida described how, when anything was suggested, 'he was ready'. However, in describing how her husband had avidly listened to the discussions between the health professionals, Rachida mimicked a dog panting. As such, having appeared to associate her husband's actions of listening to health professional interaction with canine devotion, she appears to have assumed that she shared a satirical perspective on masculine behaviour with the researcher. Conversely, Rachida may have sought to redefine the category of 'dog' – an insult in the Arab world - but possibly having had more positive personal connotations for her. Hence, despite the apparent

simplicity of the story and its depiction of a couple's strategies to circumvent health professionals' practices, the researcher's position was unresolved due to Rachida's ambiguous presentation of her husband's role.

Within the schema proposed by McCormack, accounts were understood to be given within an 'immediate social situation of storyteller and listener', and within a broader social and cultural context of understood views and positions (McCormack, 2000a: 287). McCormack understood the 'situational context,' of the interview to be configured around the relationship between the participant and the interviewer (2000a: 287). Having provided the most radical example of difference within the interviews conducted, Nawal (Y7), had migrated from San'a and suggested that she had previously migrated with her family from a rural area of Northern Yemen. She had received primary education in Yemen and did not speak English. Nawal had previously been married and had families with each husband. Her older children were aged eighteen and twelve years old and had been born in San'a, while her youngest child, who had been born in London, was four years old. Nawal appeared to have been uncomfortable in the interview context, and when she was asked whether she had undergone circumcision, she proceeded to display her infibulation scar (Y7.3). Having recounted how she was, 'worried' that she had not succeeded in being re-infibulated, and having related her, 'open' state to her inability to practice competent motherhood (see 4.3.3), she may have sought to invite the researcher to sympathise with her. Nonetheless, given the distress with which she recalled the refusal to perform a re-infibulation, Nawal may also have sought to distance the researcher, whom she perceived to be another health professional, by consciously objectifying herself to her gaze. It is also possible that Nawal assumed that the researcher was familiar with infibulation, and that she thus sought to shock her with the display what appeared to her to be deformed genitalia owing to its openness. In the event, the action appears to signal the potentially exploitative nature of research where the participants are invited to recall painful experiences of objectification within British public services.

More widely, within the framework that has been proposed by McCormack, the context of culture was understood to involve the social, cultural and structural organisation of the society in which the recounted events have been lived and in which they are re-told. An example of the use of this interpretative focus within this study is provided by an account narrated by a female obstetrician. Having criticised African women for their perceived failure to demonstrate personal agency (OBS3.10, see 5.2.4), in referring to labour pain, the participant empathised as, 'a first-world woman' with those who sought pain relief. Having continued to refer to individual practices of control over fertility, finances, and personal

fitness, as definitive characteristics of, 'first-world' women, the participant demanded, 'why can't you control pain?' (OBS3.10). Through the use of the personal pronoun, 'you' and the direct form of the question, she thus appears to have implicated herself and the researcher in the position of the, 'first world' woman. Such popular representations of, 'first-world' and, 'third-world', appear to have been taken from discourses stressing the economic and technical dependence of third-world societies. Within the context of the control of embodiment, the reference to the practices of, 'first-world' women appears to have suggested that more evolved forms of social behaviour were practised among these groups. Conversely, having described how the control of finances, fitness or fertility did not figure in the expectations an, 'African' or, 'illiterate' woman, the participant recounted how a woman belonging to these groups would not, 'feel it', where she to lose control of her body during labour. The participant described herself as being, 'Black African' despite apparently being of mixed descent. Through focussing on the representative strategies that she used to project inferior difference onto less-educated, African women, this perspective served to trace the participant's personal agency in constructing herself as a, 'first-world' woman.

3.4.3 Narrative Processes

In the course of narrating a story, participants may use specific narrative processes to embroider and to augment their accounts (Rosenthal, 1993). The schema proposed by McCormack (2000a), has identified some narrative methods as foci for systematic interpretation. Accordingly, participants have been understood to augment accounts as the narration stimulates further recollections some of which may have little relation to the story but that may nonetheless reflect the meaning of the experience recalled. The use of this approach within the study is illustrated by an account provided by, Mouna an older, Moroccan participant who had migrated from a village in the Rif mountains following the death of her first husband (M2). While Mouna had left her first child (a daughter), with her mother, she had three more children with a second husband. These were aged eight, six and two years old and had each been born in London. Mouna had received no education in Morocco, but had learnt to read and write Arabic since settling in London. Having recalled how she married young and fell pregnant after her first period at fourteen, Mouna provided an account of her first pregnancy. Having described her activities during the later months of the pregnancy, she recalled:

' One day I really froze her [her mother]. The dirt [soil] there is red... like orange. And there was like a hump in the garden. I would climb it and sit there and one day I slipped a bit and

I was sitting on the earth like that [flattens hand] on the earth. I made a little scream and when my mother came out a bit later. Oh, she screamed! She put her hands up and 'my God, my poor daughter', 'my poor daughter, what have you done?'. I didn't know what was wrong but you see, the back of my dress, on my thighs was full of soil and she thought I'd miscarried' (M2.1).

Having indicated the significance of sub-narratives that may appear to have a merely auxiliary function, the interpretative focus on augmentation served to demonstrate how, Mouna associated the physical openness of a potential miscarriage with her mother's state of emotional vulnerability. Having continued to describe how Moroccan women wear a wide belt to protect against their bodily, 'loose' state, she appears to have invested the opposition between the states of openness and closure with wider cultural and personal meanings associated with entering motherhood. These themes will be discussed at length in the following chapters and in many cases form an organising principle for understanding perceptions of maternal embodiment and the role of storytelling and information in legitimating it (4.3; 4.5; 5.2; 5.5; 6.2; 6.5).

An account provided by Nawal (I1), a younger Iraqi participant similarly illustrates how the focus on augmentation served to set patterns in participant's narratives in relief. Nawal was the daughter of a paediatrician and an engineer and was brought up in a residential suburb of Baghdad. A number of other Iraqi participants were former school friends of hers. Nawal had worked for an Iraqi migrants' association in London before taking maternity leave and she was thus well-known in the Iraqi migrant community. She had received secondary education and was improving her English through a university access course at the time of the interview. She had a child who was two months old who had been born in London. Having described how she was left alone for much of her recent labour, Nawal continued to reflect how a London GP had told her cousin she could miscarry, 'at any time'. Having been surprised that the GP refused to agree that her cousin have an early scan, Nawal suggested that that her cousin had been expected:

'... to wait three months and then go and check if the baby is alive' (I1.5).

Having listed circumstances that might suggest the foetus was already dead Nawal, stopped short of directly referencing this possibility and reported the GP informed her cousin:

'... it's weak and she's having blood every day so even maybe, the foetus is ...' (I1.5).

She returned to consider her own pregnancy, and having reported that her GP expected her to conduct her own pregnancy test, she described how she was 'very upset'. Accordingly, Nawal registered with another GP. Having described this step in terms of having 'changed her,' Nawal thus appeared to represent the health professional's relationship to her in terms of the provision of a service. She continued to describe the relationship of Iraqis to British health professionals in the following terms:

'.. the reason is we don't know our rights. It's not our culture. It's not our community. We can't deal with things appropriately' (I1.5).

Having emphasised a model of the patient as the consumer of health services to defend herself against a perception of discriminatory treatment, 'Nawal' nonetheless appears to have understood the enjoyment of rights as being contingent on the appropriate cultural conduct of migrant Iraqis. This position would appear to have reflected the transitory status of the Iraqi group in London that Nawal vigorously stressed elsewhere in her accounts. Nonetheless, by representing the enjoyment of rights as being limited to groups who assimilate to 'British' norms, Nawal also appears to have exposed the ambiguities that surround notions of patients' entitlements in the NHS. Additionally, despite her emphasis on the transitory status of Iraqi migrants in London, by associating notions of culture with those of 'community', Nawal appears to have identified both with a culture and with a diasporic group.

A further aspect of the interpretative framework that has been proposed by McCormack that was deployed within this study, related to occurrences of, 'theorisation' in accounts, during which a participant may become reflexive and offer interpretations of the experience recalled (McCormack, 2000a). This interpretative focus offered openings to exploring participants' motivations for formulating accounts as they were given and further served to characterise participants' relationships to the experience recalled. An example of the contribution made to understanding participants' positions by this phase of interpretation, occurs in an account provided by Nadia (Y5). Having been brought up in San'a, where she had received a graduate-level education, Nadia spoke good English and had migrated to Britain to follow her husband. She had not worked since arriving in Britain but had three children aged six, four and two. Each of these had been born in a large London maternity hospital. Nadia appeared to have been pleased that she had never undergone an epidural or an intervention. Nonetheless, she recalled how she had received an incorrect prediction of the date of the birth of her second child and described the effect of the information by recalling how she had felt

that, 'it's all wrong with my baby' (Y5.4). Having been provided with the, 'wrong' date she reflected that, 'it changes everything, this date, because you think it's true'. In the following account, having observed that women tend to assume that obstetricians, 'know you better than you do, so you think there's something wrong with you' (Y5.5), she described how obstetrician withdrew from communication with her during the period when the baby was believed to be overdue. Nadia described how she felt unable to ask the obstetrician, since she believed that, 'asking would make it look more wrong' (Y5.5). Having thus emphasised how she believed her embodiment to be wrong, Nadia suggested the profoundly disruptive effects of using maternity information that proved to be false. By exploring the ways in which, Nadia interpreted the events she recounted, the focus thus enabled her construction of her pregnant embodiment as, 'wrong' to be related to her investment in maternity information as a source of knowledge of the body that she may also have considered to be culturally illegitimate.

3.4.4 Language and Moments

In accordance with the understandings of the functions of narrative discussed in the introductory chapter (1.2), the interpretative framework that was described by McCormack also proposes that language provides a means to construct and give meaning to experience (McCormack, 2000a). In terms of the interpretation of the study transcripts, this perspective was used to explore the language of participant accounts as a means of communication and as a social process that occurred through the interaction of the participant and the researcher. The interpretative framework has understood the participant to be positioned through the performance of the account with regard to the researcher, with regard to the relations described in the course of the account and with regard to the larger social and cultural context of the interview encounter. Crucially, the language used in the act of narration has been understood to represent the study participant's capacity for self- definition and for innovation and has been suggested to provide a means to understand how the narrator of research accounts, 'speaks of herself before we speak of her' (Brown and Gillian, 1992: 27-28 cited in McCormack, 2000b: 310).

The interpretation of participant accounts within the study considered features of the delivery of accounts that produced an effect and examined their function of within the account and within the context of the encounter. Elements of participants' delivery of accounts that were examined in the course of this study reflected selected aspects of the interpretative framework that was proposed by McCormack (2000a). The schema identified word groups that assume common knowledge such as, 'of course' and, 'you know' as a means to

characterise the speaker's relationship to society and to the researcher (McCormack, 2000a: 293). Given the focus of this study on the maternity information-giving encounter, a new interpretative focus on participant's uses of jargon was introduced to characterise strategies of asserting professional belonging among health professional participants. Accordingly, the statement, 'healthy mum, healthy baby' that was displayed around the door of the birth centre was used by a female obstetrician to describe her function and to withdraw from considering why women might prefer to avoid intervention at, 'any cost' (OBS1.14). The same focus also served to explore the various positions adopted by Moroccan, Yemeni and Iraqi participants in their accounts of using maternity information (4.6).

The use of words that signal or demand concurrence and the use of words and phrases outside their appropriate context and meaning also formed new interpretative foci. Latifa, was a second-generation participant whose family had migrated from the Anti-Atlas region of Morocco (M9). She had received a secondary-level education in London and was married with two children aged six and four. Latifa described herself as a, 'luxury housewife' and had previously worked in an interior design business. She had given birth to both her children in a large London maternity hospital. Latifa was interviewed by the interpreter who was also a friend, and appeared to address informal advice to her when she maintained that mothers must, 'accept the baby' (M9.1). Nonetheless, in the following account she appears to have drawn on health service discourses on patient agency, to describe her religious conviction as having offered her, 'all the support' needed to continue labour without pain relief. Latifa also made use of percentages to suggest different ratios of trust that she accorded health professionals (M9.2). Hence, the focus on the use of phrases outside their usual context served to suggest how she differentiated between the context of the interview and her more informal exchanges with her friend. Her reference to notions of, 'support' also suggested how organisational discourses may be used strategically by Arab Muslim women to legitimate cultural and religious practices within NHS services.

The interpretative framework has also identified the use of the active and passive voice as foci for examining the positions taken by participants within the events they recount (McCormack, 2000a). Within the study accounts, this focus was used to explore the accounts of Yemeni participants who underwent obstetric interventions at a time when they had insufficient English to understand or to question the procedures (Y1.2; Y5.4 in 4.5.3). In contrast, within the accounts of health professional participants, the passive voice was used more widely to describe the functions and organs of the bodies of birthing women (OBS1.12; OBS2.8).

The use of personal pronouns (I, we, you), and speakers' movements between these positions, provide a further means of interpreting the subject positions of narrators and their relations to the researcher (McCormack, 2000a). This focus served within the study to characterise the position occupied by the narrator in relation to the account and within the interview encounter. An example is provided by two accounts provided by, Layla (Y1), an older, non-English speaking participant who had migrated from the Sa'dah region of Yemen during the early 1990s. Layla had married in the 1970s but had only one child who was ten years old and who had been born shortly after her arrival in Britain. While it is possible that, Layla had children whom she did not mention or who may have died during infancy, her emphasis on her lack of knowledge of birth suggests that this was not the case. Within the first account, Layla emphasised how she had not been able to maintain her embodied agency during birth. She contrasted her experience to those of, 'all the other women [who] knew so much' (Y1.2). Nonetheless, having considered the social function of maternity storytelling during a later account, she explained that sharing accounts of birth was crucial social practice for herself and her friends as, 'having children is the most important thing for us [Yemeni women]'(Y1.4). In this way, through exploring the use Layla made of 'we' [Yemeni women], her movement from a position exterior to the national group, to the heart of her social network was traced.

An additional interpretative focus that served to explore the delivery of accounts, concerned the use of repetition, false starts and hedging together with metaphors and other kinds of imagery (McCormack, 2000a). Metaphors of the hospital and the pregnant and birthing body proved to represent a particularly suggestive means of understanding the uses and meaning of maternity knowledge in accounts provided by Moroccan, Yemeni and Iraqi Arab Muslim participants (4.2; 4.3; 4.4.4). A parallel patterns of the use of spatial metaphors emerged from health professional accounts (5.3). For some health professionals, metaphors of the birthing body also represented a rich medium through with to express their own identities within the professional environment. An example is provided by the account of a female obstetrician (OBS1), who described how birthing women perceived that her presence in the labour wards represented the threat of intervention (OBS1.16, see 5.4.3). Having described intervention in terms of physical incursion into the bodies of birthing women, the participant thus appears to have invested her professional role with traditionally masculine characteristics.

In the course of narrating an account, words and phrases may signal an unexpected change in the course of events or in the narrator's position in relation to these events (McCormack,

2000a; 2000b). Within the study, repetition, pauses and exclamations such as laughter were considered to signal points at which the narrator might change the course of the account or might abandon a position that was previously occupied. Such, 'moments of change or reflection,' tended to relate to changes in participants' perceptions of themselves. Hence, in a further account provided by Mouna (M2), that described her first pregnancy at fifteen (M2.1), she recalled her mother's reaction to her stained dress and described how her mother, 'froze'. Mouna continued to explain:

'She wasn't angry though. She was happy I was OK and she said I would change after [pause]. I think that made her sad ...' (M2.1).

Having recounted how her mother considered, 'I would change after', Mouna appears to have come to a new realisation of her mother's position and her own. In this way, in the course of narrating the event, her mother's perception that her entry into motherhood was a cause for regret and tenderness may have come to represent the significance of becoming a mother for, 'Mouna' herself.

While instances of reconsideration on the part of the narrator such as that above appeared to represent, 'radical moments' (Denzin, 1994: 510), other turning points in accounts were less differentiated but nonetheless indicated changes in the narrator's position in relation to the experience recalled. Instances of participants' estrangement from the cultural fictions that they had previously used and sudden occurrences of reflection and confusion provided a particularly useful means of locating the speaker's position within accounts provided by both main participant groups. Moments of estrangement from cultural fictions among Moroccan, Yemeni and Iraqi participants related largely to the use – and rejection - of medical discourses of precaution will be discussed in the following chapter (4.3.1; 4.5.2; 4.6.1; 4.6.2; 4.7). In other cases, participants criticised representations of the homeland with which they had previously engaged. Hence, having narrated an account of the birth of her last child and her rejection by her husband, Mouna described how she perceived herself differently following migration:

'I'm different from what I was in Morocco, I've had experiences I'd never imagined I'd go through, but you can't go back. You said about the future, but in Morocco, it's about having children and making sure they survive. They survive. It's a hard life. Don't think I'm crying for it' (M2.2).

Through describing the imperative to survival in Morocco, Mouna reconfigured her relation to the experience of abandonment that – although painful – was thus suggested to have been tolerable (see 4.3.2).

Karima was a second-generation participant whose family had migrated from the Anti-Atlas region of Morocco. Having received a secondary education in London, she was married and had given birth to two children aged ten and four in a large London maternity hospital. In common with, Mouna whose account is discussed above, Karima used a strategy of disengaging from romantic representations of Moroccan life in her narrative of the migration and settlement of her parents' generation in London. Hence, having described how Moroccan parents may seek to over-determine their daughters' behaviours, she recounted how the families from which the parents of her peers had migrated remained, 'shit poor' (M6.15). Having continued to emphasise these starkly economic determinants of identity, Karima described how in visiting Morocco, she and her second-generation peers were perceived as being, 'like princesses' (M6.15). Having possibly drawn on the imaginative referents of her own childhood stories and those current in the British fantasy of the Arabian Nights, Karima thus imagined that London was imbued with exoticism and peopled by Arab princesses when viewed from rural Morocco.

By considering the interpretative categories developed from the suggestions of McCormack, each participant account was thus retold in relation to its formal and linguistic characteristics and in relation to the multiple contexts of its performance. Understandings of the delivery and contexts of the accounts were then revised in accordance with an understanding of a cycle of interpretation. Since the categories of, 'context' and, 'language,' represented the inception and culmination of this process, notes on these foci proceeded and synopsised the set of notes produced for each interview. Nonetheless, where no discernible linguistic patterns emerged the synopsising notes on language were not produced (Y6; I2; I3; I4; I5; I6). An example of the notes provided for a single account is provided together with the fragment of the interview transcript from which it was taken (appendix vi). However, since notes on context and key words related to each interview as a whole, these have not been included in the appendix.

3.4.5 The identification of themes across transcripts

An important pattern that emerged from the interpretation of the accounts of all participant groups related to the frequency with which conceptual oppositions were represented and occasionally resolved. As has been suggested in the introductory chapter (1.2), within various

versions of myths, the treatment of oppositions indicates cultural systems of organising experience. While no position on the universality of such systems has been adopted by this study, patterns of the treatment of oppositions among both main participant groups nonetheless represented classic instances of the use of oppositions to structure common means of perceiving experience. As these patterns followed a distinct form among health professionals and among groups of Arab Muslim participants, they were understood to indicate underlying cultural systems of constructing legitimate knowledge and of imagining a symbolic maternal body. Accordingly, the final stage of interpretation explored the series of oppositions that emerged from the accounts provided by each group of study participants. Patterns of opposition among Yemeni, Iraqi and Moroccan groups related to the symbolic meanings ascribed to states of natural-cultural openness and closure. While those among health professional groups related to individual agency and the problematic status of women's identifications with the maternal body.

Accounts relating to the research questions on the status of the maternal body, the construction and use of legitimate maternity knowledge and identification, were grouped and a range of positions relating these questions was established. Elements of accounts that contained oppositions relating to these concepts were used to develop two bivariate tables. One such table was produced to describe patterns across the accounts of Iraqi, Moroccan and Yemeni participants (appendix vii). Another was produced to describe themes across accounts provided by health professional participants (appendix viii). Within each of these tables, various approved uses of storytelling and maternity information were ranged along the *y* axes. Positions on the body, legitimate knowledge and identity were ranged along the *x* axes. Following indications provided by the interpretative notes, the elements entered on each axis were ordered according to the degree of identification with the other major participant group. As such, the table produced to describe patterns across the accounts of health professional participants was designed so that elements representing identifications with Arab Muslim women and with patients in general were entered the top, left corner. Conversely, elements that indicated differentiation from these groups were entered in the bottom, right corner. The table used to develop themes from the accounts of Moroccan, Iraqi and Yemeni participants, reflected a similar organisation. As such, elements suggesting participants identified with storytelling and differentiated their positions from biomedical views of the body were entered in the top, right corner. Conversely, elements of accounts that suggested participants identified with health professionals and biomedical understandings of the body were entered in the bottom, left corner.

The codes of accounts entered into these tables indicated instances of the opposition or resolution of recurring themes. Although these were associated with wider patterns of identification and difference, each of these represented independent conflicts that were variously negotiated by participants. An example of this approach is offered by the interpretation of two accounts provided by an older White, English GP participant (GP2). While she perceived the use of accounts publicised by the natural childbirth movement to relate to normative understandings of femininity, she nonetheless perceived the use of such accounts as being acceptable in the maternity service setting. In contrast, she associated practices of storytelling within, 'Asian' families with malicious attempts to establish the authority of older women within the female hierarchy (GP2.6; GP2.7). Accordingly, the use of birth accounts among, 'Asian' women to determine choices in labour, was perceived to be unjustified within maternity services. The apparent opposition between the functions of these accounts was resolved through perceptions of the insufficient ability to use such knowledge among, 'Asian' women (GP2.7). Hence, codes for each account were entered at the intersection of the categories 'storytelling in non-White cultures as an ideology' and that of the 'body as the property of the self/resistance to non-White culture' (5.2.3, 5.2.4). The development of the category of 'non-White' to describe perceptions of women from Black and minority ethnic groups within the accounts of health professional participants will be explored below (5.2.1).

The procedure used to develop themes from the interview transcripts may also be illustrated by the treatment of experiences of pain and the uses of information judged to be 'harmful' to the foetus. Two such accounts were provided by, Hanan (Y6), a younger participant who had migrated from San'a and had previously migrated from a rural region of Northern Yemen. While, Hanan had received secondary education in Yemen, she had recently migrated to Britain and did not speak English. She was married and had three children aged seven, five and four. The two youngest of these had been born in a large maternity hospital in London. An account that described how Yemeni women must accept a loss of self in entering motherhood was entered in the category indicating, 'the loss of the social self in pain' (Y6.2 in 4.3.4). Similarly, an account in which she described how she had, 'harmed' her child through accepting health professional advice, was entered in that of, 'information as harmful' (Y6.3 in 4.3.1; 4.7). Oppositions between authentic relations of belonging and inauthentic maternal embodiment appear to have been suggested where, Hanan explained that the harm represented by the health professional advice was transmitted through her blood.

Groups of stories illustrating the range of narrative strategies used to mediate the two sets of linked oppositions were selected. Clusters of accounts that were identified in this way were arranged along a scale of difference and identification with positions on identity, knowledge and the body perceived to be occupied by the other main participant group. Together with supporting interpretations, these form the study results reported in Chapters 4 and 5. Where possible stories are given in full, however given the need to emphasise certain elements of the story that illustrate the position presented through the cluster of accounts, much content was synopsised.

3.5 Ethical issues

This section describes how the ethical dimensions of the study were planned and orchestrated. The *Belmont Report* (1978), described three principles of ethical responsibility, those being, *beneficence*, *dignity* and *justice*. Since each of these principles relates to the social and cultural lives of participants in addition to their physical wellbeing, these were used to frame the ethical latitudes of the study. Specific commitments to practices protecting participant freedoms relate to each of these fundamental principles.

In accordance with the principle of *beneficence*, research practices sought to preserve participants from harm by ensuring that they did not feel pressured to disclose events they would prefer to remain private. In order to protect participants from the potential to be exploited by the publication of the research, risk and benefits to individuals and organisations that might follow from the publication of results were considered. In the case of Moroccan, Yemeni and Iraqi participants, the study represented a potential benefit as the findings would be available to be used by the community organisations in order to plan activities and to protect those that were already in place. As the findings were intended to be used by employers and by policy-makers, health professional participants occupied a different position with regard to potential exploitation in the research. However, no attempt was made to elicit accounts of discriminatory practice and where such accounts are discussed, participants were protected from exploitation by the use of codes to preserve their anonymity.

Research commitments to self-determination and full-disclosure constitute the principle of *dignity*. Accordingly, the researcher took care to explain the study's scope and objectives to each group prior to each interview. The researcher also explained the uses to which interview material would be put. Participants' consent to contribute to the study was obtained using the

same documentation across all participant groups and in both individual interviews and in focus groups. Despite these steps taken to ensure the uniformity of procedures of recording participants' consent, notable differences arose in perceptions of the potentially harmful uses of signed documents. Iraqi and Yemeni focus group participants thus refused to sign the documentation and provided oral consent. Similarly, all Iraqi participants in individual interviews (N = 6), marked the documentation with crosses representing their names and signatures. Yemeni and Moroccan participants in individual interviews also shared anxieties relating to providing written consent. Four Yemeni participants (Y2; Y3; Y4 and Y7), provided consent in this way while two Moroccan participants (M4; M7), signed the documentation with crosses or marks. This practice may highlight suspicions in other women's minds regarding written consent. Accordingly, the practice of seeking oral consent when working with vulnerable groups such as asylum seekers should be further explored.

In accordance with the principle of *justice*, participants were selected using a convenience sample that was determined by the research question. To ensure that participants were aware from the outset that their privacy would be respected, the researcher informed them that the tape made of the session would be kept in a locked drawer and accessed only by herself and her supervisors. Some participants (M2; I2; Y5; M8 and I7), asked for the tape to be destroyed. The researcher also informed participants that their accounts would not be attributed to them. She explained that these would be interpreted and reported using a system of codes.

The process of validation is believed to have provided a final means of redressing the imbalance in authority between the researcher and the researched.

3.6 Problematic areas addressed in the interpretation

Despite the overall success of the methods in gathering and interpreting the study data, a number of shortcomings were identified. These related to the use of written material to interview Moroccan, Yemeni and Iraqi participants; to the degree of privacy available during interviews with these groups and to differences in the nature of the accounts provided across participant groups. These are considered below together with steps taken to counteract possible biases that may have been introduced into the study by these means.

Interview guides

Following consultation with the interpreters, the focus group moderator's guide and the list of prompts used in individual interviews were modified to reflect the form and organisation of oral knowledge. Nonetheless, the linear form of the revised written materials in which the order of the questions related to sequential stages in pregnancy, birth and motherhood, may have discouraged women from recounting experiences that were tangential to the uses of maternity information. Such accounts might have illustrated symbolic constructions of motherhood and individual perceptions of migration that would enable uses of information to be understood within a wider context. Owing to the researcher's need to rely on an interpreter for more complex exchanges, the development of a more informal and flexible, approach was not possible. In addition, given that each participant was interviewed only once, with the exception of one who volunteered to step in for a participant who was unexpectedly absent (M1/MFG2), it was necessary to use a standardised approach. Nonetheless, in many cases, where the researcher was able to understand and communicate easily with the participant, she encouraged them to provide divergent accounts. Moreover, by explaining the literary bias of the early interview accounts, the Moroccan and Yemeni interpreters suggested that distinct patterns of organising knowledge exist within a residually oral tradition, thus serving in part to illuminate a central concern of the study (see 2.3; 2.4; 2.7).

Privacy in individual interviews with women

Individual interviews with Moroccan participants were conducted during two specially organised parties (3.2.1, see below). In the course of these events, participants who had been interviewed were able to discuss their accounts with those who had not yet been interviewed. As such, some degree of consensus among this group of participants may have been reached. Nonetheless, as this group was constituted of close friends who routinely shared their maternity accounts, the accounts of childbirth that were offered were likely to have been produced through previous interaction rather than resulting from discussions immediately prior to the interview encounter.

An additional concern relate to the presence of women than the researcher and the interpreter during individual interviews with Yemeni participants and in interviews with members of the Iraqi group. While the presence of these women may have lead participants to omit some accounts, in no cases did they interrupt or correct participants' accounts. Non-participating women were also friends of participants rather than family members. As such, they may be broadly expected to share the participant's outlook, or at least to have been aware of her views.

While the negative effects of the presence of listeners within the interview encounter with Yemeni and Iraqi participants may not be considerable, some positive effects followed from the presence of non-participating women in interviews with all Arab Muslim participant groups. Accordingly, by contrasting 'public' accounts produced in the presence of other women and those produced in the, 'privacy' of the encounter with the researcher, the narrative construction of, 'public' experiences and meanings was identified. Such accounts contributed richly to the patterns of negotiating the series of oppositions that represented emerging cultural identifications among these groups (4.7; 6.7). An example provided in an interview with a Moroccan migrant participant (M2), related to the discussion of the participant's bisexuality and the possible institutionalisation of bisexuality in polygamous marriages. When a second women entered the interview room, she appeared to scold the participant for attempting to shock the researcher. As the participant did not contradict the second woman, and smiled at her suggestion of horseplay, the meaning of the account became unclear. Nonetheless, the change that appeared to follow the entrance of the second woman clearly demonstrated how public accounts of sexuality may be veiled through strategies of levity. As such, 'public' accounts addressed to the researcher (the interpreter) and a non-participating woman provided valuable suggestions of the ways in which Arab Muslim participants would like to be seen by their peers.

The nature of participant accounts

Having focused on the ways in which embodied experiences were imaginatively constructed through plot, metaphor and other narrative strategies, the methods appear to have privileged the positions of participants who gave more developed accounts. Inevitably, where translation was undertaken, some aspects of the accounts of participants who contributed in Arabic may also have been lost. However, through the use of back-translation and through carefully questioning of the interpreter, it is believed that the loss of important elements of these narratives was minimised.

More serious concerns related to the accounts provided by Yemeni participants who were non-English speakers or whose level of English was insufficient to allow them to express themselves freely. These accounts were relatively bare and lacking in detail and consequently these represent a disproportionately small part of the findings. Additionally, the positions adopted by participants in the Yemeni group had important similarities with those described by Moroccan participants in their more developed accounts. Given the relative lack of detail

in accounts provided by the Yemeni group, these have tended to be discussed together with those of Moroccan participants.

Iraqi participants and many of those in the health professional group provided highly figurative accounts through which their own positions were clearly visible and in which their use of metaphor enabled their relations to others to be traced. Accordingly, these accounts were discussed in greater detail than were those of other participant groups. Despite these limitations, the narrative methods used provided abundant material on the means by which embodiment was invested with meaning across all participant groups. The effectiveness of narrative methods in exploring how experiences are produced through narration favours small participant groups. The relatively limited discussion of the accounts produced by Yemeni participants thus represented a casualty of the success of these methods.

3.7 Summary

The chapter has introduced the narrative inquiry methodologies that were used in the study and has illustrated the contribution made by the methods used. An overview of the data collection methods described how the study used exploratory focus groups with Moroccan, Yemeni and Iraqi participant groups to develop an approach to individual interviews. Since a consensus on legitimate knowledge and perceptions of motherhood was not sought from health professional participants, focus group interviews were not undertaken with these groups. Understandings of narrative identity and the symbolic and lived bodies were demonstrated to have been brought together through the work of Merleau-Ponty. Having proposed that the embodied self existed in a web of natural-cultural relations to the world, Merleau-Ponty later proposed that the experience of the self that was realised through language. The study has understood participants to configure their embodied and cultural selves through narratives. Accordingly, where narratives of the use of legitimate knowledge of the body are sought, the relation between symbolic and lived bodies may be explored. Elements of participants' accounts were discussed in order to demonstrate the function of each of the interpretative, 'lenses' used (2000a; 2000b). Through attending to the multiple contexts of the interview and through noting her own position in relation to the participant and the account, the researcher obtained a highly reflexive perspective on participants' account that provided the basis of the interpretative process. By exploring the use of narrative processes within accounts, the section described the means by which the relationship of the narrator to the account suggested themes that will be discussed in the following chapter. Having provided brief biographical sketches of the Moroccan, Yemeni and Iraqi participants

whose accounts were discussed, the section also served to suggest the individual positions from which these participants contributed to the study. Themes were identified across accounts and transcripts by entering the codes of participant accounts into a bivariate table. Frameworks of opposition between these themes will be discussed in the conclusions of Chapters 4 and 5 (4.7; 5.7), and within the concluding Chapter (6.7).

The following chapter will describe the findings produced from the accounts of the Moroccan, Yemeni and Iraqi study participants.

Notes to Chapter 3:

[1] The decision to use interpreters attached to the community associations created a relationship founded on a financial transaction where access to the women (both English and Arabic-speaking) was often presented as part of the translation work. Additionally, given that participants were aware that the community association would provide the interpretation, the preferences of English speaking women to be interviewed in Arabic may have related in part to a perception that they would thus provide a benefit to the organisation. Nonetheless among the Iraqi group, preferences for speaking in (mostly standard) Arabic appeared to relate more broadly to cultural reasons.

[2] As the responses to the list of demographic questions were not subject to quantitative analysis, these have not been termed questionnaires.

Chapter 4:

Narratives of maternal knowledge and belonging among Arab Muslim women in London

4.1 Introduction

This chapter will describe how individual Moroccan, Yemeni and Iraqi participants described their birth experiences. It will also explore how participants in these groups used maternity information and storytelling to understand the transition to motherhood. By exploring patterns across these accounts, the chapter will begin to chart common themes that structure participants' narration of Arab Muslim maternal selves. In order to identify these themes, it will discuss a series of relationships between participants' accounts of their embodiment; their uses of maternity knowledge and their expressions of multiple aspects of cultural belonging. The second section (4.2), will explore participants' views of pregnancy as a period of change and cultural indeterminacy and will consider participants' embodied identifications with pregnant women from other cultural groups. A distinction between Moroccan and Yemeni participants and those belonging to the Iraqi participant group will be formulated in terms of vernacular and nationalist patterns of identification. The section will consider ways in which maternity storytelling was used by Moroccan and Yemeni participants to construct local and regional homeland identifications in London. Moroccan and Yemeni participants' references to embodied agency will be explored as these accounts supported similar patterns of identification. The third section (4.3), will consider Yemeni and Moroccan participants' negative evaluations of maternity information together with their accounts of the significance of pain during first labours. In the fourth section (4.4), Iraqi participants' maternity accounts will be discussed as these served to articulate nationalist identifications. The section will close by examining Iraqi participants' references to the natural and cultural dangers represented by the maternal accounts of their rural and working-class compatriots. By examining perceptions

of health professionals and of the functions of maternity information held by participants in each group, the fifth section (4.5), will discuss ways in which each group constructed cultural difference. In the sixth section (4.6), participants' accounts of their uses of maternity information will be traced as these served to represent their maternal embodiment. The section will examine accounts of the use of visual images of birth and scanned images of the foetus as these relate to divergent constructions of the symbolic body and of the ties to the imagined homeland that were configured through these.

The Iraqi, Moroccan and Yemeni communities that have settled in London each have a distinct history and maintain separate class, regional and sectarian affiliations (2.2). These differences were reflected in the composition of the participant groups. Accordingly, participants in the Yemeni group had migrated from the agrarian North East of the country or came from rural-urban migrant families who had settled in San'a (3.2.1). While the majority of Moroccan participants maintained ties to villages in the Rif and Anti-Atlas mountain ranges, the majority of Iraqi participants had migrated from Baghdad (3.2.1). On the basis of the accounts of participants who described their neighbourhoods, this group has been assumed to have migrated from the more affluent residential suburbs of Central West and West Baghdad (3.2.1). While the Iraqi group continually stressed their intention to return to Iraq, no such suggestions were made among the Moroccan and Yemeni groups (4.7). Nonetheless, as will be discussed below, these groups actively sought to maintain links to their regions of origin.

While this study has sought to trace individual participants' negotiation of culture through their accounts of embodiment or their accounts of the body observed, it has also aimed to produce new knowledge on the cultural dimensions of motherhood and the maternity information-giving encounter. As has been suggested above (1.2; 3.4), a series of conceptual oppositions arose in the accounts of both main participant groups. In order to identify common themes across accounts, clusters of factors within the story line of participant accounts were deployed to explore this series of relations within the accounts of each main participant group. Conclusions are structured around the relation of these binary pairs to a central opposition that concerns participants perceptions of women's states of natural-cultural openness and closure during birth and early motherhood. Individual participants' uses of these oppositions in their individual maternity accounts suggest a diverse range of ties to imagined national, local and cultural origins.

4.2 Pregnancy as a period of orientation to cultural identity

This section introduces the discussion of the patterns of articulating cultural belonging that emerged from participants' accounts of entering motherhood. The first sub-section (4.2.1), explores Moroccan, Yemeni and Iraqi participants' representations of pregnancy as a period of transition and discusses participants' accounts of identification with the pregnant bodies of non-Arab women. The second sub-section (4.2.2), introduces a typology of vernacular and nationalist identifications that was used to organise the differences between the accounts provided by Moroccan and Yemeni participants and those provided by Iraqi participants. Moroccan and Yemeni participants' concerns with establishing relations of cultural belonging are explored as these focussed on how maternity storytelling might be used to imagine links to places of origin. Within the third sub-section (4.2.3), Moroccan and Yemeni participants' representations of the loss of embodied agency are traced as these suggest the participants' changing patterns of belonging to the homeland and to the migrant community.

4.2.1 Pregnancy as a period of cultural indeterminacy

Participants across groups perceived pregnancy to represent a period of transition during which embodied identifications with other pregnant women gained a defining importance. Such identifications with their changing embodied state and with those of other pregnant women led many participants to suspend their perceptions of cultural identity and difference. Accordingly, during the focus group interview with the Moroccan group, an older second-generation participant (MFG5), explained how in becoming pregnant, 'you become part of a club' (MFG2.5). The participant thus suggested that the physical changes of pregnancy served to initiate women into a collectivity of all pregnant women. The same participant continued to explain how, during pregnancy she was:

'... accepted as a mum by a lot of people who wouldn't talk to you otherwise... because they might have though I was too religious' (MFG.2.5).

In this way, it appears that she perceived that her identification with her imminently changing status was mirrored by other women who would otherwise withhold recognition from her. The participant continued to reflect:

'You think, everyone's pregnant, there's going to be a baby boom [laughter] You know - Everybody's having babies'(MFG.2.5).

Having exaggerated her account to comic effect, the laughter of the group suggested that they shared the participant's perception of having experienced an enlarged sense of community

during pregnancy. In this way, the group appears to have agreed that, other pregnant women became suddenly visible during pregnancy. Nonetheless, participants did not perceive that universal bond created by the shared experience of pregnancy continued into motherhood. Accordingly, an older, early migrant participant (MFG2), recalled that:

'... after the birth 'though, it was totally different, because the language I talk to my children is Moroccan [Arabic]. It's a different life' (MFG2.2).

The participant thus perceived that entering motherhood involved reproducing group boundaries. Nonetheless, having considered identifications during pregnancy, she continued to comment that:

'... when you're pregnant, you look the same, it's like you could be the other woman' (MFG.2.2).

Having referred to the possibility of taking on the identity of other pregnant women, the participant confirmed the view of the first speaker. Both participants perceived that embodied identifications with other pregnant women served to obscure ethnic and cultural ties of belonging during pregnancy.

The second participant continued to emphasise that becoming a mother entailed adopting a cultural identity. Thus, she explained, 'you have to be definite, you have to make decisions for the baby' (MFG.2.2). Similarly, while she reflected that, 'when you're pregnant, you just feel you're going to change' (MFG.2.2), she considered that in entering motherhood, 'the responsibility makes you grow up' (MFG.2.2). Thus, the participant appears to have understood that in adopting maternal identification, women also took on adult selves. A similar suggestion that women took on an adult cultural self in becoming mothers was made by participants across groups. Accounts provided by Yemeni and Moroccan participants that associated this change with the notion of birth as the death of the pre-maternal self will be discussed below (4.3.4). Similarly, Iraqi participants' accounts of entering motherhood will be discussed in relation to the construction of a culturally authentic maternal role (4.4.2; 4.4.3).

Participants in the Iraqi group also perceived pregnancy as a period of indefinite cultural identification. Thus, an older participant (IFG4), explained how she drew on her mother's experience to understand pregnancy and the transition to motherhood. Nonetheless, she recalled how her perception of a bond with other pregnant women gained a considerable importance to her during her pregnancy:

'... when I went to clinic and saw the other ladies I felt so close to their hearts' (IFG.4.4).

Another older Iraqi participant (IFG2), also recalled having identified with other pregnant women solely on the basis of their pregnant state. She explained that while walking in public spaces:

'... you see these women and you can't help staring at their bodies! [laughter] No, because you imagine what it must be like (IFG.4.4).

The women's laughter and the participant's effort to correct her account and to establish that she was attracted to these women through their shared experience of pregnancy suggested that Iraqi participants may have been embarrassed by considering the physicality of pregnancy. Nonetheless, the participant's own comment indicated that the embodiment of pregnancy provides a powerful basis for transcultural identification. Having suggested a similar view, a younger participant (IFG6), remarked that non-Arab women, 'look at you like friends although you don't know them' (IFG.4.6). While a further participant conceded that: 'it's true that you have the same experience,' (IFG.4.1), the same participant continued to remark that the first speaker was fortunate in having her mother living close to her since, 'it's your mum who is always there and you follow her pattern' (IFG.4.1). It thus appears that the participant differentiated between the shared physical experience of pregnancy and cultural patterns to be followed during motherhood.

Perceptions of pregnant identification across cultural difference were more muted in accounts provided by the Yemeni participant group. A recent Sudanese, migrant participant (YFG.1), who had previously lived in an asylum-seekers' hostel, described her perceptions of another pregnant woman who lived there:

'I didn't want to think of her like that. She was a bad woman, a bad mother' (YFG.4.1).

Having expressed her reluctance to recognise the pregnant state of the woman whom she judged to be, 'bad,' the participant appears to have suggested that, in normal conditions she would identify with other pregnant women. Having further suggested this view, a second younger, Yemeni participant (YFG4), responded to this comment by recounting that:

'... when you see a pregnant lady, English or not, you think, ' that is my friend''(YFG4.4).

Similarly, an older participant (YFG3) who contributed in Arabic, responded that, 'it's the first thing you think'(YFG4.3).

4.2.2 'Vernacular' identifications and the functions of maternity storytelling

Framing participants' accounts of the transition to a fixed, maternal identity were their concerns with the nature of their relationships of cultural belonging to the homeland. Participants' perceptions of cultural belonging diverged according to their national group or their family origins. Moroccan and Yemeni participants adopted, 'vernacular' identifications that entailed constructing links to the homeland through reproducing local, regional and neighbourhood practices. The majority of participants in these groups maintained ties to rural localities. Nonetheless, two highly-educated, Yemeni participants (Y2; Y5), who identified with, 'vernacular' discourses of belonging, maintained links to the conurbation of San'a. Iraqi participants adopted, 'nationalist' conceptions of the homeland. These identifications were articulated through establishing an essence of national belonging that was defined against the identifications of other Iraqi groups.

Iraqi, Yemeni and Moroccan participants used maternity storytelling to reproduce authentic relations of belonging to the homeland. Through listening to these accounts, participants imagined that they adopted fixed cultural identities. Iraqi participants similarly used maternity storytelling within the family to establish ties of national belonging (4.6). Practices of group storytelling also played a foundational role in conceiving and articulating regional and local belonging among Moroccan and Yemeni participants. Accordingly, in describing why she had sought her mother's maternity accounts of pregnancy and birth, an older, early migrant Moroccan participant recounted how she had sought to know, 'what it felt like for other Moroccan women' (M1.2). The comment thus represented culture and sensations of birth as being continuous. Nonetheless, the participant continued to describe these accounts as, 'giving me my culture' (M1.2). As such, having suggested the continuity of culture and individual sensation in her mother's experience of maternity in Morocco, the participant appears to have imagined that Moroccan culture existed outside her individual self. Having been imagined to be separate from individual experience, the participant thus perceived that Moroccan national culture was transferred as a complete entity through the medium of her mother's accounts. The mother's account of the embodiment of her own pregnancy and birth was then used by her daughter as a source of authentic meanings through which to organise and understand her own maternal embodiment.

A similar conception that maternity storytelling represented a link to family origins emerged from the account of a younger, Yemeni participant from the Sa'dah region of Northern Yemen (Y4). She described how her mother recounted her experiences of her own early pregnancies:

'... she was walking all the time because she was with the sheep... she saw different things, not just the inside [of a house]...They walked in something like a big circle. Everyday... rocks, different colours... different things When she was walking, she was getting big, but it makes the time pass and it makes the baby sleep. The same way, I walk around my house. Like I'm there' (Y4.6).

Having used the same method of walking to ease the weight of the foetus and to lull it to sleep, the participant perceived her pregnant embodiment through her understanding of her family origins. She also appears to have sought to transpose the markers of her family's grazing land onto her home in London through the meanings that she thus attached to the weight and movement of the foetus as she walked around her home. As such, the participant used her mother's maternity accounts to transform her own pregnant embodiment into a bridge that linked her to her mother's working practices during her first pregnancy in Yemen.

A younger, Moroccan participant who had migrated to from the Anti-Atlas mountain region when she was six years old (3.4.2), also located her pregnant embodiment within a frame provided by her mother's accounts of birth in the homeland. Having described how learning she was pregnant had represented, 'a real shock' to her, the participant recounted how she listened to her mother's maternity accounts later in pregnancy. The participant described the effects of these accounts on her perceptions of motherhood:

'... it made all the difference - just listening to my mum. What it was like to give birth in Morocco. How the midwife came and there was no light to see by and they would block the windows to stop everyone hearing her crying [cries]... and thinking that it was my time to hear the stories' (M8.2).

Having focussed on the steps taken to muffle the sounds of labour, and having emphasised the lack of technology available to her mother, the participant stressed her mother's experience of labour pain but also emphasised her embodied capacities. Hence, through listening to her mother's accounts of her unassisted births in the village in Morocco during the early 1970s, the participant placed her pregnant embodiment in a chain of maternal experiences that linked her to rural Morocco.

An older, Moroccan participant who had migrated from a village in the Rif mountains when she was eight years old (M3), described a similar use of her mother's accounts:

'At the start when I was sick and I wasn't sure if I was pregnant, my mum was sure of it. She would tell me how it was for her...my mum was lucky she wasn't far from her mum when she was pregnant. They were making carpets and they used to work outside the house. Like in the garden but just with a wall. There was a street the other side, with people passing... The house was too dark [for working] so that's why they were there. Really until my mum couldn't sit up straight to work, her mum used to tell her about the babies and my mum used to tell me, so I'm part of that too (M3.9).

The participant thus associated the awareness of her pregnancy with the working practices of her mother and her maternal grandmother. While working together, the two women were able to share accounts and to discuss motherhood. The participant's account of the dark spaces of her paternal grandmother's house and the light courtyard demonstrated how her mother's narrative enabled her to reconstruct the house where she had passed her early childhood and to locate it in the village and in the social and economic life of the village. The participant's suggestion that her mother was able to listen to these accounts only as long as she was able to work, suggests the central importance she accorded to maternal strength in configuring ties to family history and to the family village. However, having continued to describe her own storytelling practices with her Moroccan friends, she also maintained that:

'I've taken her place [laughs]. Twelve hours of labour. So now we are just the same' (M3.9).

In this way, by sharing accounts of her own embodied experiences of labour and birth, the participant reproduced the familial and social context of the village. Through these acts of embodied and cultural reconstruction, she also suggested that she established her adult status in relation to her mother and in relation to the Moroccan identification that her mother represented.

A further pattern that emerged from accounts provided by Moroccan participants concerned the use of perceptions of embodied agency as a characteristic definitive of Moroccan motherhood. A group of second-generation and early migrant Moroccan women related this practice to an imagined rural homeland that other second-generation and migrant participants considered to be idealised (see 3.4.4). Nonetheless, having described her mother's accounts of returning to the fields after birth, an older participant who migrated from the south of Morocco during her early childhood, recounted how she had used these accounts during her first pregnancy in London:

'... they allowed me to have confidence that I could do it. If my mum could walk out all tied up and work all day. I could do it. It's all to do with responsibilities that Moroccan women have' (M1.4).

The mother's action in entering the fields wearing a belt that is wrapped around the hips and is used to, 'close' the, 'open' bodies of Moroccan women immediately after birth (3.4.3), suggested the contradictions that underlie this account. Notions of, 'responsibility' which appear to have rested on the dualist categories of public and private, body and mind (4.4.1), were thus uneasily accommodated with the reference to the 'open' natural-cultural state of the mother's body. Having suggested a similar pattern of imagining an essence of national belonging, a second-generation Moroccan participant (M6), whose family had migrated from the Agadir region, described the effects of her mother's accounts:

'I mean she had all her kids with no pain relief or anything. She knew what she was doing.. I wanted that kind of birth to give me the comfort of being at home. I don't understand why more of us [Moroccan women in London] don't do it. I mean... we've got everything here. Why can't we do it?' (M6.6).

The participant thus deployed notions of maternal embodied agency to define the boundaries of the national group in London. Nonetheless, having referenced Morocco through a domestic reference ('home'), and having maintained her identification with the group ('we'), she did not appear to have sought to have established an essentialist notion of Moroccan motherhood. Similarly, having been asked to consider how Moroccan notions of motherhood differed from perceptions of motherhood within other groups, the participant described how:

'Moroccan women think of themselves as mothers - it all goes back to the way women live in the country. Women would need to get up and go to the fields the next day, because the men aren't going to. They're in the fields with their children all the time. It's their whole life' (M1.2).

In this way, the participant perceived notions of Moroccan motherhood to derive from rural working practices similar to those described in her own mother's accounts. Nonetheless, these were not suggested to be necessarily accommodated in urban patterns of living in Morocco or in migration. Rather, they appear to have represented a construction of the homeland that served strategically to establish a common identity with other rural and working-class migrants from the South of Morocco.

4.2.3 Storytelling and the loss of maternal resilience

Moroccan, Yemeni and Iraqi participants described how they assuaged concerns surrounding the nature of their relations of belonging during pregnancy and early motherhood through undertaking practices that signalled their cultural authenticity. Since participants in all groups also associated these practices with notions of effectively nurturing their children, these were termed maternal *competencies*. Moroccan and Yemeni participants perceived storytelling to have represented a central maternal *competence* as it served to configure links to the homeland through women's embodied agency in labour and birth. As these conceptions of embodied agency or embodied sensation were tied to women's daily working practices (4.2.2), where these related to establishing links to the homeland they were termed *resilience*. The significance of *resilience* as a practice that signalled women's cultural belonging was suggested where women recalled the loss of embodied agency during their births. Accordingly, having described how she had undergone an emergency caesarean section, a younger Moroccan, second-generation participant (MFG8), explained that she had no knowledge of the birth. As such, she recounted:

'I didn't know anything. No, I wasn't strong [able] enough. I don't have anything to tell her. In that way it's like I'm more her sister [others protest]' (MFG.9.8).

Having related her lack of sensation during birth to a lack of knowledge, the participant recalled her perception of her physical, 'weakness' but may also have suggested her mental and moral deficiency in failing to maintain *resilience* in birth. Additionally, having related her loss of *resilience* to an inability to tell her own birthing story, she perceived that this inability to contribute to maternity storytelling confined her to a role analogous to that of her daughter. Nonetheless, her suggestion of her insufficient maternal and hence - adult - status was contested by other participants. Thus, the participant's perception of her culturally inauthentic entry into motherhood appears to have been considered as harmful by the women who listened to her account.

Having recalled a similar experience of what may be understood as a culturally inauthentic pregnancy, an older Yemeni participant from the Sa'dah region (Y1), recounted how she was unable to understand maternity information in English. Having had insufficient knowledge of pregnancy and birth, the participant recounted that she had been unable to relate to other women's birth accounts. Hence, she explained:

'I felt useless because I didn't know how I would have them. The women I know are so full of stories about having children. I thought I should know but I was like a child too'(Y1.2).

As the participant imagined the stories to, 'fill' the other women with knowledge of maternal embodiment, so having been unable to access maternity accounts, she perceived her empty state as having been ineffectual. Within this account, as in the other discussed above, having lacked embodied knowledge of birth, the participant perceived herself as being unable to make the cultural transition to motherhood. Similarly, have failed to locate her own maternal embodiment within a cultural framework, the participant perceived that she had remained in a state analogous to that of a child.

4.3 Dangers to the body-mind continuum and the meanings of pain

This section explores negative evaluations of maternity information that invite women to imaginatively project into the potential harm posed themselves and their babies by changes in their embodied states (2.3). Within the first sub-section (4.3.1), Yemeni and Moroccan participants' accounts of the effects of information given in the, 'precautionary mode' are considered. Through exploring the accounts of a primarily Moroccan group, the second sub-section (4.3.2), introduces perceptions of the dangers posed women by representations of physical and psychic states of vulnerability during birth and early motherhood. Yemeni and Moroccan participants' accounts of the use of storytelling to project through such representations of danger will also be examined (4.3.3). The final sub-section (4.3.4), discusses accounts of the temporary loss of self during first births that were provided by the same participant groups.

4.3.1 Embodied agency and the critique of the 'precautionary mode'

The accounts of migrant and second-generation Yemeni and Moroccan participants advised women against attending to maternity information where this served to invite them to project into situations in which they or their children were harmed. An older Moroccan, early migrant participant (M1), recalled the importance she had attached to maintaining a positive psychic condition during pregnancy. The participant explained how her first birth was proceeded by four miscarriages. Nonetheless, she recounted how she undertook a range of physical activities during this pregnancy. The participant explained:

'... if I'm happy... you know my mood will affect the baby... and it will be born happy too' (M1.5).

In contrast, having described the attitude of her GP, the participant commented:

'... he was always advising me against doing these things, 'oh Mrs. X, I really would think about the risk'' (M1.5).

Having thus associated the position of her GP with a discourse of precaution, the participant continued to contrast this view against her own beliefs by recounting how she considered:

'... if this one's to be, I'm not going to worry about it, it's better that I don't' (M1.5).

An older, Moroccan migrant participant (M2), also described how her GP urged her to use maternity information to project possible harm to herself and child. Having suggested a similar view to that of the first participant, she demanded:

'What is the point of me hurting [worrying] and the baby getting weak because of something that has only happened to some other women? I have to protect me and him [the baby] (M2.1).

Having referenced the same belief that information on potential dangers may weaken the foetus through the mother's anxiety, the second Moroccan participant (M2), appears to have perceived avoiding such as representing a form of maternal *competence*. As such, the same participant expressed her respect of the religious commitment of Islamist women in London, but criticised practices of seeking maternity information that she perceived to be prevalent among this group. Accordingly, she explained that Islamist women who used maternity information sought to:

'... try and guess what will happen, that's not my religion. It's very English I think' (M2.1).

Similarly, the participant characterised women who sought certitude about their births through using maternity information. She thus described how this group:

'... don't come from the countryside. They're the ones with nice houses'(M2.1).

As such, having appeared to perceive that maternity information might obscure the fortuitousness of a healthy birth, the participant criticised women's practices of seeking clinical estimates of risk from a position of belonging to the working-class of the homeland and to a rural locality. A younger Yemeni participant, who had previously migrated from a rural district to San'a, similarly described how listening to information on potential hazards to the pregnancy, 'hurts,' the baby. Hence she explained :

'... these things, they hurt the baby, the baby becomes nervous eh, not right [for the] baby, you know because, the blood...All things happen between the mother and the baby' (Y6.3).

The participant continued to recount how a student midwife believed her pregnancy to be, 'at risk' as a result of having misread the projected delivery date in her notes. The participant described how she convinced the obstetrician not to correct the delivery date. Having explained how she refused to accept his apology for having initially believed the midwife, she recounted how:

'... nobody listened in the hospital, nobody ever does listen and that's why I was so worried... I don't want to ask somebody about what they're doing all the time. Not doctors' (Y6.3).

Given the danger represented by the perception that her pregnancy was at risk, the participant felt that she had been obliged to interrogate this information. She perceived this position as having being inappropriate to her relationship with obstetricians and suggested that her need to question the obstetrician had implications on her ability to trust him with her care. Perceived through this encounter, the participant viewed all health professionals in the maternity hospital as having been unresponsive to her needs.

A position shared by Moroccan and Yemeni participants that was associated with the view that information on potential dangers to the pregnancy served to menace maternal equilibrium, understood that maternity information invited women's fears of labour and birth. In this way, an older Yemeni participant from San'a (Y5), recounted how, 'if I have a worry, it's disturbing for the baby coming' (Y5.12). Having criticised women who were perceived to prepare for birth by having the, 'time of day,' predicted or by visualising, 'what kind of room it will be' (Y5.12), the same participant contested the basis of maternity information provision to facilitate women's imaginative projection into birth. Similarly, a Moroccan early migrant participant (M1), commented that health professionals' injunctions on women to seek maternity information assumed that, 'the birth is really important and then the child does what it wants' (M1.7). The participant further suggested the cultural significance of avoiding maternity information on potential risks to the pregnancy, having described how she was, 'ashamed' of her desire for information, 'to be ready' during her later pregnancy (M1.5).

4.3.2 Embodied agency and the dangers of maternal openness

A view that appears to be linked to the conception of embodied agency as the foundation of maternal *competence*, perceived that the transgression of bodily boundaries during birth and in nurturing the child were ontologically - and culturally - disruptive to women. Having been suggested to inform Islamic reproductions of culturally authentic motherhood (see 1.6), Moroccan, Yemeni and Iraqi participants represented breast feeding as a privileged maternal practice. An example of this view was provided by the account of a younger Iraqi participant from the Al-Mansur residential district of Baghdad (I1, see 3.4.3). Having described how a friend abandoned breast feeding her child, the participant cited the woman's husband's repudiation of her maternal *competencies*, 'what kind of mother are you?' (I1.9). The participant continued to explain, 'and it is really very, very important' (I1.9). In this way, rather than having sympathised with her friend, the participant suggested that the significance of breast feeding was such that she concurred with the husband's view. Having appeared to associate breast feeding with national belonging, a younger Yemeni migrant participant (Y6), similarly reproved co-migrants who abandoned the practice by noting that they, 'change when they come here' (Y6.1). A younger, second-generation Moroccan participant (M10), maintained that, 'my point of view is that Muslim person actually has more feelings' (M10.9). This participant suggested that the heightened sensibilities of Muslim mothers were manifested through the practice of breast feeding. Hence, she described how:

'... a good mother is, you know, knows what she's doing - you know... breast feeds her baby at the right time' (M10.9)[1].

In this way, the participant perceived knowledge and ability to breast feed infants as a defining characteristic of virtuous Muslim motherhood.

Participants viewed breast feeding as a maternal *competence* when it was performed effectively. Conversely, where midwives were perceived to fail to support mother's attempts to nurse their babies, Moroccan participants suggested a powerful sense of distress that the boundary between mother and child should be breached. An older Moroccan participant recounted how, 'midwives have no idea what it's like for women,' and described her experiences of breast feeding as being, 'like pulling a wire through your nipple' (M1.6). She thus appears to have criticised the lack of support for breast feeding among NHS midwives from the perspective of an embodied experience of transgression. An older, second-generation Moroccan participant (M5), who sought to breast feed her child similarly described how she had insufficient support from her midwife. The participant described how her nipple, 'nearly fell off, it was so sore and cracked' (M5.4), and thus imagined her efforts to feed her child in

terms of a fantasy of bodily fragmentation. Having commented, 'that's how you show you love your child', the participant, broke off her account by remarking, 'I mean, blood...in the milk' (M5.4). The participant thus juxtaposed ideas of maternal virtue with her apparent sensations of revulsion. Accordingly, she appears to have indicated that the dysfunctional openness of her body had posed a threat to her cultural identification as a mother. Having similarly protested against the failure of health professionals to teach mothers how to breast feed, another older, second-generation Moroccan participant recounted how blood seeped from her nipples into the milk (M6.9). She recalled that the situation was, 'terrible', as her nipples were, 'actually...cracked' (M6.9). The participant described how she and the non-Moroccan women on the maternity ward were, 'forced' to continue painful breast feeding as the midwives restricted access to formula milk. The participant closed her account by again referencing the presence of blood in the milk, and recalled, 'I mean blood... in the milk. I never expected that' (M6.9). She thus appears to have associated her inability to effectively breast feed her child with a radical sense of disorientation in addition to that of disillusionment. As she and other participants associated effective breast feeding with maternal *competence*, her suggestion of her personal disorientation may further suggest the significance of establishing ties of cultural belonging in adopting a maternal identity.

A further illustration of the relationship between incursion into bodily integrity and the transgression of cultural identity, is offered by the account of an older Yemeni, participant from San'a who had previously migrated from a rural area (Y7, see.3.4.2). The participant described how her request to be re-infibulated after her birth in London was refused. Having referred to the recently opened scar tissues as being, 'hard', the participant protested that as a result of not being re-infibulated, the wound was 'open - like bleeding' (Y7.3). She continued to describe how, in being open, the state of the vulva was equivalent to its state, 'in labour' (Y7.3). Having continued to describe qualities required in the practice of motherhood, the participant stipulated that, 'you have to be strong and instead I have this' (Y7.3). As she associated the open edges of the scar with weakness and the continual act of birth, she also appears to have perceived this physical opening to have effects analogous those associated with the seeping of blood from nipples in the accounts of other participants. As the open state of her body could only have been symbolically analogous to its state during labour, her reference to the maternal strength was denied her through this state, would appear to relate to a cultural identification with feminine bodily integrity. While participants' accounts of painful breast feeding described a physical impediment to caring for the child, the emphasis they placed on the presence of blood in the milk also suggested that, in bleeding from the nipples, participants transgressed a symbolic conception of the *competent* maternal body.

4.3.3 Peer accounts and fears of natural-cultural openness

As Yemeni and Moroccan participants suggested that states of embodied openness entailed ruptures in their relations of cultural belonging, so participants in these groups considered vicarious experiences of openness to pose a threat to their identifications with *competent* motherhood. Hence, while an older, Yemeni participant from Sa'dah advised a pregnant woman to listen to stories, 'to prepare yourself' (Y1.4), for birth and motherhood, she described how vision offered women a different and disturbing kind of knowledge. Accordingly, in describing women's reactions when confronted with images of birth, the participant reflected that:

'I mean it's hard. If you see someone that minute, with their legs open, you know, when the baby is just born (sic). You would be so scared'(Y1.4).

Nonetheless, having associated the impact of visual knowledge of physical openness with a fear of entering motherhood, the participant explained that motherhood represented:

'... a huge step in your life, your friends will all be there wanting to tell you. They will be happy for you'(Y1.4).

In contrast to the tableaux of maternal bodies that were continually open and continually in pain that the participant suggested was offered by visual images, she thus imagined that storytelling served to valorise women's transition to motherhood. Since participants' friends appear to have all been Yemenis, the participant also appears to have viewed storytelling as a means to establish bonds within the migrant community.

Yemeni and Moroccan participants emphasised the sequential character of narratives of birth as a means to delimit the disruptive possibilities of bodily openness. Accordingly, an older, Moroccan migrant participant (M2), described over-hearing her mother's screams during the birth of a sibling in terms of a, 'picture' that she sought to dislodge during her approach to labour (M2.2). Conversely, she recounted how, during her first pregnancy, she had sought, 'other women to tell me how it was – how it ends really' (M2.2). Hence, while she associated a visual representation of birth with a permanent state of embodied openness and pain, the participant sought narratives of birth to place her fears of labour in the context of entering motherhood.

Participants also recalled that they had maintained a sense of self during labour and birth through drawing on peer accounts. A younger, Moroccan early migrant participant who

described her experience of labour pain in terms of being turned, 'inside-out' also recalled the ways in which she used peer stories during her birth:

'... this pain... when you feel you're not really there... that was what I expected. Even when I was seeing things, it didn't frighten me, because I absolutely trusted what my friends had told me' (M8.5).

In this way, the participant perceived that, having imaginatively projected into the event through other women's stories, she was able to understand her experience of labour pain.

An outline of the accounts that Moroccan and Yemeni participants used to prepare for birth was appears to have been provided by an older Iraqi participant from the Al-Rashid district of Baghdad:

'... they have lots of talking and the midwives are either good or bad. What my sister [in law] says is always dramatic. Always the child is in danger and then [breathes deeply to suggest relief]. Do you see what I mean?' (I2.7).

Having suggested that stories of birth and labour typically entail a trial that is passed, this account pointed to ways in which peer accounts were used by Moroccan and Yemeni participants to project through the natural-cultural danger represented by the fear of pain.

A further example of the use of storytelling to project through states of physical and cultural indeterminacy associated with birth was provided by an older, Moroccan migrant participant (M2). The participant explained that having given birth to her youngest daughter she was rejected by her Jamaican husband who abducted and hid an older daughter. She continued to describe the Moroccan custom of wrapping the mother's abdomen in tight material because it is, 'loose' following birth. The participant recounted that she was still, 'bleeding' when she returned to her flat (M2.3). As the participant did not describe physically debilitating effects of her bleeding state, she appears to have related her state more broadly to the understanding of maternal, 'looseness' following birth. Accordingly, she appears to have emphasised the cultural and social dimension of her liminal state where she explained that having returned to her flat, she found that her husband had stripped it of curtains. She described how she was unable to breast feed her child as she could be seen by strangers walking in the park outside her window. Conversely, having described how she and her neighbour found sheets to drape across the windows and having recounted how a contact with a social worker led to her reclaiming the second daughter, the participant moved the narrative focus away from the threat posed by natural and cultural indeterminacy following birth.

4.3.4 Labour pain and the loss of self as a passage to motherhood

Yemeni and Moroccan participants who sought to configure links to imagined origins through notions of *resilience* perceived that birth accounts provided a highly ambiguous means of taking on competent maternal identities. Having understood the woman's emotional state and the safety of her embodied foetus, Yemeni and Moroccan participants thus sharply criticised women who provided exaggerated accounts of birth as they perceived these to represent a threat to the pregnancy. Accordingly, an older, Yemeni participant from San'a considered women who would tell such accounts to be, 'bad, really bad' (Y5.5). By recounting, 'oh it was all day. It was twenty-four hours' she suggested that women might gain respect from their peers (Y5.12). Nonetheless, the success of this strategy appears to have been limited as the participant recounted that women who engaged in malicious storytelling this group would socialise only among themselves.

Despite the risks entailed by the fear of labour pain, Yemeni and Moroccan participants perceived that the awareness of the embodiment of the child and the experience of labour pain itself served to prepare women for the change represented by entering motherhood. In this way, an older Moroccan migrant, focus-group participant from the Anti-Atlas region (MFG3), who described how her children represented, 'my life' also recounted how, 'I have no life for myself' (MFG.12.3). In responding to this comment, an older, second-generation participant (MFG5), described how during the first pregnancy, 'you do feel that you are not you anymore' (MFG.12.5). She recounted how, during early motherhood, 'you feel swallowed up... it's really frightening' (MFG.12.5). Having thus drawn on a metaphor of feeding herself to the role of mother, the participant suggested that she experienced the transition to motherhood as a processes of extinguishing her sense of self. Accordingly, the participant recounted how when the child's foot moved in her womb she realised that:

'.. .that's it, that's the day your life's finished. Never the same now' (MFG.12.5).

As such, the change represented by motherhood and that signalled by embodied knowledge of the foetus' foot, also represented the end of the participant's pre-maternal existence. Similarly, in approaching the birth of her first child, a younger second-generation Moroccan participant recalled that she, 'couldn't take' the implications of motherhood (M9.6). Nonetheless, she urged that :

'... from then on, when she feels the baby... the lady... she should feel that she is not anymore free' (M9.6).

Having returned to consider the loss of freedom that she experienced in entering motherhood, the participant recalled that:

'... it isn't just at this moment that you feel it. You're not anymore free once you've had the baby... once he's here you know that that's it' (M9.6).

Having thus contrasted, 'freedom' with women's embodied knowledge of the foetus, the participant appears to have recalled an unmitigated sense of impending loss that continued throughout the period of pregnancy. Somewhat differently, a younger Yemeni participant from San'a (Y6), described a conversation with another Yemeni woman who had attempted to abort her foetus and also referenced the woman's perception that in becoming a mother, 'her whole life was over' (Y6.2). Nonetheless, having imagined the woman to ask, 'where's the baby?' the participant appears to have ascribed the woman's wish to abort to an insufficient embodied awareness of her pregnancy (Y6.2).

A similar pattern of representing labour and birthing pain as a form of embodied and cultural knowledge of the loss entailed in entering motherhood was related to wider conceptions of femininity by an older Moroccan, migrant participant (M2). The participant described how she was able to, 'run like a boy' when pregnant with her first child (M2.4). However, she recalled that after the birth of the child:

'... you belong to your baby and your husband... because you need him [the husband] for everything' (M2.4).

Having thus suggested that in becoming a mother she became dependent on her husband, she recounted how she had previously been a, 'free spirit' and explained:

'I mean, to be honest, I had some quite close friendships with men just after I was married but when the children came, that stopped' (M2.4).

While the participant may have referred to casual social interaction, given that the Moroccan translator interrupted the participants' later account of her, 'friendships' with women, these relationships are likely to have had a sexual character (3.6). Thus, having appeared to have referenced her pre-maternal sexuality, the participant recounted how her, 'close friendships' came to be established with women since they, 'understand the children come first' (M2.4). The participant recalled her passage to motherhood as having been marked by her experience of labour pain:

'When you give birth, the pain is... it's too strong... like you are just a like him [the baby] compared with the pain' (M2.4).

In this way, the participant suggested that she adopted a maternal role through realising the continuity of experience between herself and her child. She continued to recall her experiences of entering motherhood in terms of the baby's helplessness:

'– you can't do anything – like when your baby is born. It gives you the feeling that it is a part of you you're looking at and you have to think for that part of you' (M2.4).

Having thus related her experiences of the emotional and physical vulnerability occasioned by labour pain to an awareness of the child's dependence, the participant linked this perception of the physical grounds of the bond with her children to a fantasy of her continued embodiment of the child as, 'part of you' (M2.4). Hence, the participant represented the schism in her own identity involved in becoming a mother through her experience of pain. Following the experience of vulnerability and the loss of a sense of self in pain, the participant thus imagined herself to have taken on an additional, 'part' of herself and as having reconfigured her relationships with others to accommodate this change. A similar pattern may be traced in the account of an older, Yemeni participant from San'a (Y2), who recalled her expectations of labour and birth through asking, 'because it's my child. Honestly, you expect to suffer for it, don't you?'(Y2.2). Having described her most recent birth, the participant referenced her first labour and explained:

'It was like the first time... I felt it was me who was being born again, I didn't know what I was doing [laughs]' (Y2.2).

As labour pain diminished the participant to an infant state, she also recalled that the, 'sudden' pain - possibly that of crowning - during her first birth represented the moment that, 'you look back on' (Y2.2). Having described the change of identity entailed in entering motherhood, the participant contrasted the qualities demanded in motherhood with those required prior to becoming a mother:

'... you need to be strong. For example you might be funny or clever and this is good for your friends but for a baby that's no good at all... the baby doesn't know you like that... you get selfish because you have to. The baby needs you for everything and you have to give it everything' (Y2.4).

As such, the participant made a distinction between women's physical and intellectual capacities with the baby's needs for the mother's body having been seen to prompt the mother's, 'selfish' retreat from social life. Similarly, having recounted how the experience of pain signalled a women's entry into motherhood, a younger, Yemeni participant from San'a (Y6), warned:

'... if she does not say this thing to herself [accepting the pain] she will never be a good mother. She will never look after the baby. She will be able to ignore it' (Y6. 6).

The participant appears to have seen women's failure to accept labour pain to carry the penalty of bad motherhood. Taken together with the accounts reported above, a shared view appears to have emerged among Yemeni and Moroccan participants through which labour pain was valorised for its perceived function in temporarily suspending the woman's sense of self. Through interrupting the woman's perception of herself, participants in these groups perceived that labour pain serve to mark the transition to motherhood as a cultural role. While an account discussed above (Y2.2), compared the experience of pain during a later birth to the mother's rebirth, these account of the significance of labour pain related more fully to the first birth.

The discussion of feminine displays of suffering in Christian Mediterranean societies provided above (1.6), explored how experiences of pain may represent an exclusively feminine means of cultural expression (Dubisch 1995; Rossi 1986). Nonetheless, while reproductions of masculine suffering among Shi'a groups and the role of the mothers of martyrs in Arab nationalist discourses appear to represent similar modes of expression, pain did not serve among Yemeni and Moroccan participants as a continual trope of feminine experience. Rather, the embodied experience of pain functioned within participant accounts as a symbolic death – and re-birth - of the mother into a fixed configuration of relations to the homeland. Thus, as Yemeni and Moroccan participants perceived the entry into motherhood to entail a fracture with the previous self, they understood their experiences of labour pain to initiate them into the awareness of *resilient* embodiment as a link to local, regional and domestic settings in the homeland.

4.4 Individual maternal agency and problems of cultural 'closure'

This section explores how accounts provided by Iraqi participants constructed a symbolic body around their practices of willed agency. In order to configure their own embodiment through notions of this symbolic body, participants in this group constructed a distinct set of maternal *competencies*. Within the first sub-section (4.4.1), participants' conflation of national and Muslim identities within the accounts of this group are examined in relation to their construction of cultural difference. The second sub-section (4.4.2), investigates how participants fabled class identities through drawing on, 'Islamic' obligations on women to provide the cultural instruction of children. Participant's attempts to define such *competencies* against, 'British' maternal practices - and against other Iraqi identities - are considered in the following sub-section (4.4.3). The final sub-section (4.4.4), considers how the *responsible* symbolic body produced by Iraqi participants was used by this group to control representations of authentic national belonging.

4.4.1 Islam as an informing cultural context for Iraqis in 'exile'

Having consistently defined themselves as, 'exiles' rather than as migrants, women belonging to the Iraqi participant group tended to emphasise their educational and family background in order to differentiate themselves from earlier Iraqi migrants (2.2). Participants in this group also drew on references to Islam in order to differentiate the group from the identifications perceived as, 'British' and those perceived to have been characteristic of working-class Iraqis or other Arab migrant groups in London. An example of the ways in which Muslim identifications were used within this double process of differentiation was offered by the accounts of an older, Iraqi participant from Mosul who was originally from the Al-Rashid district of Baghdad (I2). Having described how previous generations of Iraqis had migrated to Britain, 'to make money', she emphasised how the Middle-class dissident group had been forced to migrate. She outlined the merits of the group within Iraqi society:

'... we belong to a certain group of people... and we have certain views... but we are Iraqi and we are very useful in Iraq. I don't see why this situation should mean my children are confused and that they belong nowhere'(I2.2).

The participant thus associated the identity of her children with her professional contribution to Iraqi society and with that of the middle-class, Iraqi dissident community. She also tied her children's sense of belonging to the political roots of the migration of this group. Having emphasised the political and professional dimensions of her maternal identity, the participant also drew on a Muslim identification to describe how she had initially understood the passage

to motherhood. Thus, within a later account she recalled how, while preparing for the birth of her first child in Baghdad, she had read popular tracts available, 'on the street' that, 'were about being a Muslim woman' (I2.9). While she explained that these were not, 'religious books like that because they were in Iraq' the participant described how, 'I think about these things more now' (I2.9). Having returned to consider the birth of her first child, she recalled that in becoming a mother she became suddenly aware of, 'how your child will see you, how it will grow'. The participant suggested that the spiritual dimension of motherhood had become more salient to her as she considered rearing her children in London as she reflected that, 'everything needs more thought here' (I2.9). Accordingly, she appears to have deployed the Muslim identifications that she had partially adopted in entering motherhood in Baghdad in order to imagine the boundaries of the national group in London. Having thus used Muslim identifications to define an Iraqi identity, the participant thus appears to have suggested she was able to produce a sense of belonging to Iraq in her children.

A younger Iraqi participant from the Al-Mansur district of Baghdad (I1), also drew on identifications with Islam as the primary axis of difference between Iraqi political dissidents and British society. In this way, having described how she intended to teach her children, 'to pray, to fast, to do these things', she explained her motivation for passing on Islamic practices in terms of ensuring:

'... that they're proud of themselves as Iraqis here. So that they don't change so much' (I1.1).

The participant also described how, 'because we are Muslim,' Iraqi mothers in London had, 'a duty to protect our children from anything outside our religion' (I1.2). Nonetheless, she illustrated these religious duties by explaining how the Iraqi families she knew discouraged inter-Muslim marriage outside the national group (I1.2). Thus, where the prescription Islam that believers must seek to establish equality within co-religionists conflicted with the preservation of the boundaries of the Iraqi exile community in London, the participant disengaged from wider identifications with the umma.

4.4.2 Willed agency and the negotiation of cultural difference

Women within the Iraqi group tended to emphasise the, 'Islamic' imperative on mothers to provide the cultural and social formation of their children as the basis of relations of belonging to the homeland. In this way, an older, Iraqi participant (I2), recounted that in London children, 'need someone to guide them more' (I2.2). Having continued to define practices of the instruction of children against those of, 'feeding them and something like that,' the participant privileged intellectual over physical maternal capacities (I2.2). Having

reflected a similar hierarchy of maternal capacities, a younger Iraqi participant from the Al-Qadisya district of Baghdad (I6), described how, 'giving the child food' represented, 'the simple thing of motherhood' (I6.4). The participant described how her nurturing practices resembled those of her French, Catholic sister-in-law. Nonetheless, she predicted that differences between her views of motherhood and those of her sister-in-law would increase over time since, she explained:

'... a Muslim mother... you think about your child being a good person and you try to influence that. I used to be quite girlish, you know? Not very responsible. Always out, shopping... chatting. Now I'm such a different person... Now I feel more responsible. I'm enjoying this responsibility' (I6.4).

As this Iraqi participant appears to have configured a maternal cultural identity around practices of maternal instruction, so participants across the Iraqi group represented the transition to a *competent* maternal identity through similar practices of instruction or of using maternity information to project or regulate the body. Iraqi participants drew on these in ways analogous to the uses of models of *resilience* among Yemeni and Moroccan participants. These practices will be termed *responsibilities* as they appear to relate closely to constructions of the self-responsible subject set out above (2.3.1). Having illustrated how notions of *responsibility* served to imagine a maternal identity, a younger, Iraqi participant from the Al-Rashid district of Baghdad (I5), defined her understanding of motherhood against possible identifications with the physical care of her children:

'... teaching them the good behaviour and this is all responsibility, it's not about only giving them food'(I5.8).

As the participant represented motherhood in terms of exemplifying desirable social behaviour so, having continued to envisage the cultural formation of the child, she predicted that the need to practice such maternal *responsibilities* would expand, 'as your child becomes, you know... social' (15.8). Having described how she read, 'old Arabic stories that aren't really for children,' to provide material for storytelling, the participant recounted:

'Even how I carry myself - I feel I've got more weight to myself you know' (I5.9).

In this way, the participant suggested that, through instructing her son, she had accessed cultural resources that served to enrich her self-understanding. Similarly, she concluded that her practices of instructing her children also enabled her to, 'think clearly' (15.9).

While the participant thus suggested that her practices of instruction enabled her to imagine ties of belonging to Iraq, within a later account she also described how her storytelling served to establish the boundaries of her son's identifications. Hence, having described how she sought to provide him with stories in order to guide his perceptions of other religions, the participant suggested that, were she not to undertake this practice:

'... he will think it's bad or it's not you know, something I would respect... you have to be responsible for how he will understand them' (15.4).

Having contrasted her storytelling practices in London with those required in Baghdad, where rearing one's child was, 'more straightforward', the participant nonetheless appears to have sought to reproduce Baghdadi discourses of identification within her accounts of cultural and religious difference in London[2] (15.4). The participant described how her provision of cultural meanings to her experiences of migration for the benefit of her son had also entailed changes in her self-perception:

'... that's what makes you grow – with him. Because you have to explain things all the time'(15.4).

Having perceived herself as being obliged to decipher experiences of migration, the participant appears to have associated practices of maternal instruction with establishing or preserving particular ties of national belonging. Hence, in common with the other participants whose accounts were discussed above, she appears to have sought to transpose her own professional, metropolitan and political discourses of belonging onto her children through her practices of storytelling.

4.4.3 Class, ethnicity and Muslim maternal responsibilities

Iraqi participants appear to have defined the aspects of national belonging that they transmitted to their children against their perceptions of cultural difference. By drawing on notions of the *responsible* symbolic body, Iraqi participants sought to establish their maternal identifications against British, English or working-class Iraqi groups that were characterised through the physical practices of motherhood.

An older, Iraqi participant from Mosul who had grown up in the Al-Rashid district of Baghdad (I2), described how her experience of English family life was limited to television soap operas and talk shows. Nonetheless, she speculated that the emphasis on conflict between mothers and daughters in popular media representations of English families indicated that familial conflict represented a social and cultural norm. The participant continued to explain:

'English mothers love their children, I'm not saying anything else, but it's like I was saying before, that's not enough always' (I2.3).

In this way, the participant appeared to include, 'English' women in the category of mother. Nonetheless, she suggested that the mothering practices of this group might be insufficient to support a continued relationship with their children. Conversely, having recounted how, 'knowing your child... that takes the energy' (I2.3), she suggested the privileged status conferred on the relationship with the child within Iraqi mothers' storytelling practices. Similarly, having maintained how, 'what's so important is the talking', she described how her stories to her children related to:

'... Baghdad, about my childhood and the rest of the family, about life here' (I2.3).

Hence, by interpreting her own youth and her family life in Iraq, the participant also sought to interpret her life and that of her children, 'here' in London.

As Iraqi participants perceived maternal *responsibilities* to be represented through women's practices of instructing their children, so they appear to have conferred on children a distinct status from an early age (see 4.6.2). Accordingly, the same participant whose account was discussed above, described that her practices of storytelling to her children derived from an awareness that:

'I'm a mother to a person – not something that needs to be fed, changed and things like that'(I2.4).

The participant thus suggested that women who understood motherhood through the physical care of their children failed to relate to their children as individuals. She also implied that such a view of motherhood, through which the child was represented as being inanimate ('something'), served to reduce the child's status as a person.

The participant continued to consider the maternal bond within the, 'English' families portrayed on television and remarked that:

'It's always going to be deep but the child might feel left out - like his mother might be more concerned, as I've seen happen - with her husband. Either that or the mother works such long hours she can't do anything with him' (I2.4).

While appearing to have suggested that the mother-child bond was inevitably profound, the participant also suggested that where the separate status of the child was not recognised, the privileged relationship of the Muslim - or Iraqi - mother to her children could not be preserved. She thus represented the mother-child relationship as having been in particular need of protection against the pressures exerted by asymmetric gender relations within the, 'English' family and against the, 'English' organisation of women's work.

Iraqi participants similarly used the opposition between physical nurturing and maternal storytelling to contest the potential claims to national belonging that might be voiced by the Iraqi working-class in Iraq and in migration. An example of this strategy was provided within the account discussed above (I2.4). Accordingly, having been prompted to consider that some Iraqi mothers might emphasise physical aspects of the care of children such as sleeplessness, the participant demanded:

'... who are these women? They're not from Baghdad!' [laughs] (I2.4).

Having suggested that the origins of this group were obscure, the participant appears to have sought to question the basis on which their practices might have been representative of authentic Iraqi motherhood. Furthermore, having again referenced British television representations of maternal-child conflicts, the participant characterised this non-metropolitan group as being, 'just like TV mums' (12.4). She continued to recount how women in this group, 'buy certain things, baby foods, especially washing powder' and reported that women in this group believed that if they, 'sit' with their children during the period of maternity leave, 'then they've done their bit' (I2.4). The participant explained that, despite spending time with their children, non-metropolitan, Iraqi women migrants, failed to recognise that, 'it's important to stay at home to know your child' (I2.4). Hence, the participant presented the maternal practices of this group as having been based on an incomplete perception of the significance of the individual relationship with the child as the basis of culturally authentic motherhood. Similarly, having projected onto this group identifications with, 'English'

patterns of consumerism, work and family conflict, the participant appears to have sought to counter claims to Iraqi national belonging that might be made by this group.

An account produced during the Iraqi focus group interview further illustrated the role of class in configuring nationalist notions of motherhood. Having been prompted to consider the significance of the second scanned image of the foetus through which the sex of the baby can be established, an older participant from the Al-Mansur district of Baghdad (IFG2), remarked that, 'of course we all drown our girls' (IFG7.2). The comment was accompanied by much laughter, and thus appears to have been perceived by the group at large to have to have successfully deflected the question. Nonetheless, despite the success of this strategy, a second, older participant (IFG3), continued to remark:

'... in some neighbourhoods [of Baghdad], girls don't go to work although their families really need the money. These women want boys' (IFG.7.3).

Hence, while the first participant deflected the question on the significance of the gender of children, the second participant sought to associate the same perceived suggestion of generalised misogyny towards female children, with the division of labour in Iraqi working-class families. Having sought to differentiate the participant group from the purported practices of the Iraqi working class, a younger participant from the Al-Qadisya district of Baghdad (IFG4), remarked that, 'we are here and we are all educated' (IFG7.4). Taken together with the reference to, 'some neighbourhoods' in the previous comment, the suggestion that, 'all' the group survived childhood and were educated, appears to have functioned to represent the experiences of this group of middle-class Iraqi families as having been representative of gender relations in Iraqi families as a whole. In contrast, the preference for boys appears to have been associated with traditions within a working-class group in which no decision was imagined to be made regarding women's work within individual families, but nonetheless, 'girls don't go to work'[3].

Having referred to the physical tasks of, 'feeding and changing' children with which British mothers and Iraqi working-class women were perceived to identify, an older Iraqi participant who was from the Al-Rashid district of Baghdad, recounted that, 'you could get a nanny or a babysitter for that' (I2.3). As such, she appears to have located the physical care of children in a culturally neutral, public sphere in which they might equally be rented as services from British mothers or from the Iraqi working class. Thus, while Iraqi participants perceived that *competent* maternal practices of intellectual agency served to confer cultural belonging within

a familial space, they did not perceive that the physical care of children demanded a particular cultural or religious affiliation.

4.4.4 Public narratives of pain and authentic identifications

Iraqi participants sought to establish the authenticity of their relations of belonging to Iraq through representing the maternity storytelling practices of non-metropolitan and less-educated Iraqi women. Given that Iraqi participants constructed notions of *responsible* motherhood around their practices of willed agency, they perceived the purported birthing accounts of these groups to have represented a culturally inauthentic practices. Accordingly, the same older, Iraqi participant (I2), whose accounts are discussed above, described how, 'women who have children and don't do anything' and who are from the, 'villages in Iraq' (I2.7), publicly recounted their experiences of labour and birthing pain. She continued to comment that:

'... they really like telling the stories... in the villages in Iraq a lot of the women are storytellers' (I2.7)

Similarly, having reflected that the practice was in decline in Iraq since, 'now all women can read' she appears to have opposed these purported practices of public storytelling to notions of modernity (I2.7). Having further suggested the association of *responsible* motherhood with an elevated social status, the participant explained that:

'... the ones [women] who work in the community don't like to talk to people who aren't close to them about all that' (I2.7).

The participant thus appears to have associated the purported maternity storytelling practices of rural Iraqi women with a low level of participation in the migrant community. Taken together with her perception of the low educational attainment and social status of these groups, she appears to have viewed representations of maternal pain as being socially and culturally stigmatising. Another, older Iraqi participant from the Al-Qadisya district of Baghdad (I6), perceived the public practice of maternity storytelling to introduce a dangerous fluidity between the opposing categories within which nationalist identities were constructed. The participant recounted how women from rural communities in Iraq, gathered around a Qur'ān-ic school to exchange narratives of birth that described:

'... how terrible labour was and all this blood... they don't talk about it as if it's important for having the child - just this blood and being like an animal' (I6.6).

Having referred to pain as a state of, 'being like an animal,' the participant suggested that such accounts were, 'disrespectful to other mothers' and suggested that these served to, 'upset other women' (I6.6). In contrast, having represented, 'what you give your child', and having been perceived to serve to consolidate feminine relationships within the family, the participant understood the knowledge of pain in labour and birth to be meaningful only within the familial sphere (I6.6). The participant appears to have imagined that, where working-class or rural co-migrants described their indeterminate natural-cultural states during birth, their accounts served to collapse the system of hierarchic opposition within which *responsible* motherhood was formulated. Within this account, as within that discussed above, the socially disruptive possibilities of narrating experiences of pain was associated with women who, 'come from villages' who are not, 'professional' (I6.6). The participant further described how such narratives of bodily transgression that she imagined to be shared among working-class, rural Iraqis, represented, 'their way of keeping together...as we are all here' in London (I6.6). Accordingly, by suggesting that these accounts served to bring a nightmarish disorder into the social world, the participant appears to have indicated wider tensions within this de-territorialised group around the control of representations of feminine national belonging.

4.5 Cultural difference in the information-giving encounter

This section traces the use of competing discourses of motherhood and femininity within accounts of the information-giving encounter provided by Moroccan, Yemeni and Iraqi participants. The first sub-section (4.5.1), explores participants' perceptions of the devaluation of motherhood in NHS maternity services as these related to the symbolic maternal bodies constructed by each participant group. Within the second sub-section (4.5.2), Moroccan and Yemeni participants' views of the, 'precautionary mode' of information-giving are explored. Participants' patterns of fabling the experience of intervention are also traced within the accounts of the same groups. The final sub-section, considers defensive strategies of legitimating the loss of agency that were described by non-English speaking Moroccan and Yemeni participants (4.5.3).

4.5.1 Perceptions of the devaluation of motherhood in NHS maternity services

Participants from each group described encounters with NHS health professionals in which they felt that health professionals withheld their recognition of the personal undertaking involved in entering motherhood. Nonetheless, within these accounts, participants constructed cultural difference in ways that reflected their divergent perceptions of the symbolic body. Appearing to have reflected the model of the *responsible* body, an older, Iraqi participant (16), described how in Iraq, health professionals would, 'know from their families

what is important for you' (I6.4). She related the information-giving practices of Iraqi health professionals to shared perceptions that:

'The mother's job is to understand and to keep well and I think that's not something that happens here' (I6..4).

Having further suggested the central place of intellectual agency as a maternal *competence* among the Iraqi group, the participant continued to advise women to carefully read clinical books on maternity in order to phrase their questions in appropriate terminology. Where questions were not carefully formulated, she perceived that London-based health professionals, 'don't care' about the effects of information given on the mother (I6.4). The participant continued to suggest further aspects of her perception of *responsible* motherhood. Having suggested that the social benefit entailed in childbirth, 'is important for everyone' (I6.4), she concluded that, in using NHS maternity services, 'you feel that you're not welcome to their care' (I6.4). Having perceived that, 'they are there for us after all' she thus drew on the public basis of NHS care as a means to claim her right to equitable care (2.3.1). Similarly, by emphasising that obstetric care exists to meet the needs of mothers, she also deployed a notion of consumer needs to make the same claim (2.5.1). A younger, Iraqi focus group participant who was also from the Al-Qadisya district of Baghdad (IFG1), similarly justified her criticism of the reduced significance of motherhood among NHS health professionals by drawing on discourses of patient choice. Accordingly, she explained the difficulties encountered in determining the value of information provided by health professionals:

'... it's not that you think they don't know. It's that you think they would say anything because they don't care or they're tired. How can you chose when they're not doing their job?' (IFG.1.1).

Having suggested the distinct nature of the *resilient* symbolic body, an older Yemeni participant from Sa'dah (YFG6), did not reference notions of patient choice or to draw on the public basis of NHS care to inform her perception of the antagonistic difference represented by NHS health professionals. Following a comment that, 'British' midwives, 'let you know they don't like you', she suggested that midwifery represented, 'more of a job' in London (YFG.1.6). The participant continued to explain NHS midwives' views of birth:

'... it's all about work. Making you do this and that and it's OK, if the baby comes easy [sic]. But sometimes you're not made like that and the baby is big' (YFG.1.6).

The participant thus presented midwifery in the NHS as entailing the management of women's bodies. Having been trained using this model, the participant suggested that NHS midwives were unable to understand the embodied processes of birth. In contrast, the participant presented Yemeni midwives as being concerned with, 'bringing joy' to women (YFG.1.6). She thus appears to have indicated that the inability of NHS midwives understand the embodied processes of birth resulted from the disjuncture between the biomedical model and the *resilient* symbolic body. However, she also implied that, through failing to understand the *resilient* body, NHS midwives were unable to recognise the wider social and cultural significance of birth.

A perception of NHS health professionals' lack of understanding of the significance of birth to women was also outlined during the Moroccan focus group interview. Having described how she had hoped to have the same midwife for her second birth as for her first, an older, second-generation participant (MFG8), described how:

'It doesn't feel right to share that experience with someone you don't know. Like you're a cow that's having a calf, it's not the same experience because they don't really know you and you can't get to know anyone, as a person when you're in that much pain' (MFG.4.8).

The participant thus implied that women in labour were protected from disturbing identifications with the body by the supportive presence of a midwife with whom they had established a relation of trust. Nonetheless, the participant continued to describe the cultural context of birth in NHS:

'... there's no sense that you've seen a life start that will - in šā' allah - go on after. They tell you what to do, but they don't think that you're a mother and your whole life is changing' (MFG.4.8).

Hence, by emphasising actions that need to be imposed on the birthing body, the participant perceived that NHS midwives failed to understand the embodied process of birth as the transition to a distinct maternal role. Given the perceived inability of NHS midwives to recognise women's embodied agency as the basis of this transition, the participant understood that NHS midwives were unable to support women through the loss of self that was elsewhere associated with the passage to motherhood. The magnitude of the natural-cultural danger represented by labour pain where *resilient* conceptions of the maternal body were not shared by health professionals (4.3.2), was suggested by the ascription of bestial identifications to birthing women who were not provided with recognition of the value and meaning of their experiences of labour pain.

The construction of maternity information was also perceived by Moroccan and Yemeni participants to intervene in her relationship to the *resilient* body. Some ways in which maternity information was structured by biomedical models of the body were suggested by an older, second-generation Moroccan participant (MFG4). Having described the effects of considering photographs of birth in a book lent by another participant, she recalled:

'... those horror pictures... it's not useful. It's really shocking... I didn't want to think of my baby that way [other women agree]. It hurts in a way. It made me look at the baby from outside... I didn't need it at that stage. I was thinking at one point, I don't want it that badly' (MFG.8.4).

Thus, the participant suggested that viewing the photographs obliged her to consider her child from a position external to herself. As she described the images as, 'horror pictures' she appears to have associated this process of exteriorising her child with the transgression of bodily boundaries similar to that represented in horror films and literature. Accordingly, having emphasised the violence entailed in enabling her to, 'look at the baby from outside', the participant appears to have suggested that the pain ('hurt'), and shock of considering such images derived from a symbolic action equivalent to the excision of the foetus from her body. Hence, by encouraging her to project into labour and by offering exteriorised perspective on labour and birth (2.3), the participant appears to have perceived that models of the biomedical body fundamentally disrupted her embodied and cultural identification with her child. Having continued to recall the effects of considering cross-sectional diagrams of foetal development, the same participant contrasted the objective focus of these images with her bond with her embodied child:

'It's like falling in love, and someone filmed you and it looked just awful... You don't need them [diagrams] to know your baby's growing [other women agree]. You've got proof of that because of the backache, and the sickness... (MFG.8.4).

Having represented the diagram as having offered less tangible, 'proof' of the development of the foetus than that offered by her own embodied sensation, the participant appears to have contested the veracity of this visual representation. Nonetheless, her description of the effects of visual information in projecting her out of her embodied position, demonstrates that through using maternity information the participant's relationship with the *resilient* body had been strained. Other Moroccan participants who were present readily agreed with the positions the speaker described in the course of the account. Accordingly, Moroccan participants appear to have widely perceived that their identifications with embodied agency were compromised where they used maternity information.

4.5.2 The 'precautionary mode' of information-giving as a practice of coercion

As Moroccan and Yemeni participants considered visual information given within the, 'precautionary mode' to have served to obscure their awareness of their embodiment, so these participants also perceived health professionals' projections into birth to have posed a threat to their physical-psychic equilibrium. Within conditions of labour in the obstetric wards of a large maternity hospital, Moroccan and Yemeni participants recalled that health professionals abused their medical expertise to ensure that they consented to interventions. In this way, a younger Yemeni participant from Sa'dah (YFG4), described how she accepted health professionals' advice to undergo intervention by recalling how, 'you're so afraid and you think that your baby will die so you agree' (YFG.5.4). Similarly, following the comment of a participant who had reassured the group that maternal and health professional priorities coalesced, an older, Yemeni migrant participant (YFG5), recounted:

'When you talk to the other women you start to think, 'all of them couldn't have been in trouble' but... what would you do if it was true and you lost the child?' (YFG.7.5).

The participant expressed doubt in the saliency of information provided by health professionals for women to make decisions on intervention. Nonetheless, she also suggested that women in labour were in no position to question this information.

Moroccan participants perceived health professionals' use of the, 'precautionary mode' to pose a direct threat to maternal *resilience*. An example of participants' association of information-giving with the loss of embodied knowledge of birth was offered by a younger, early migrant participant (M8), who commented that, 'they make you feel you are weak and that you will not succeed' (M8.5). Having thus described the effects of information-giving, the participant continued to contrast these with the effects produced by storytelling:

'... if you didn't already know what is [was] ahead of you, you would give in because you can't resist them if you don't already know the pain is not hurting the child'(M8.5).

Having described information-giving as a practice that Moroccan women sought to, 'resist' the participant thus appears to have perceived these institutional practices as being antagonistic to *resilient* maternal practices. Similarly, within the Moroccan group interview, a younger, second-generation participant (MFG6), described how she was informed during labour that, 'the baby's in distress'. Having reflected that the deployment of this term, 'just quiets people up', the participant continued to recall how during her birth:

'... I was thinking, 'of course it's in distress. It's hard. It's trying to get into the world'' [laughter] (MFG.9.6).

Having taken issue with the ways in which the notion of, 'distress' was deployed, the participant appears to have sought to directly counter the, 'precautionary mode' by drawing on discourses of *resilience*. The laughter occasioned by her comment and a supporting suggestion of, 'emotional blackmail' suggested that this view of maternity information-giving as serving to impose alien constructions of the body on Moroccan women was shared by the other participants. In apparent contradiction, an older early migrant Moroccan participant, maintained that, 'you've got to trust the doctors' (M1.6). As the advice was provided in the form of an injunction, it is possible that the imperative to trust health professionals may be used in advice to peers. Nonetheless the participant continued to explain:

'What I don't want is for the baby to be at risk, but I think they exploit that and they misinform you. But that's less important than the baby being OK' (M1.6).

Having added this caveat, the participant also suggested that health professionals might use the, 'precautionary mode,' of information-giving to ensure that women complied with their preferred routes through labour and birth. Accordingly, where participants accepted health professionals warning of the potential harm posed to the child by delaying intervention, the perceptions of, 'emotional blackmail' that were suggested above, appear to have remained.

Given the importance of embodied knowledge of pregnancy and birth in configuring links to the *resilient* conceptions of motherhood, some Moroccan participants recalled interventions as acts that imposed the desires of health professionals on their bodies. Participants recalled these acts as having served to displace their own agency in birth. An example was provided by the account of a Moroccan, early migrant participant (MFG8), that was narrated during the focus group interview. Having recounted how she had consented to an intervention that was, 'pushed on me' the participant recalled that she, 'always felt I missed that moment when I became a mother' (MFG9.8). As she suggested that health professionals pressurised her into accepting the intervention, so she also referenced the belief that labour pain marked women's passage into *resilient* motherhood (4.3.4). The participant continued to represent the experience of intervention through images of her vulnerability to the desires of health professionals. Thus, having imagined how in giving birth, 'I was flat out on a table', she continued to describe how the procedure of the caesarean was, 'violent, and it's not easy to think about afterwards' (MFG.9.8). Following from this account, an older, second-generation participant (MFG4), reflected that, 'you feel the baby's just kind of yanked out' (MFG.9.4).

Having suggested the violence of her own experience of intervention, she continued to protest that, 'it's some doctor that touches it first' (MFG.9.4). The participant ironically addressed the child thus handled by the obstetrician with, 'welcome to the world' (MFG.9.4). Accordingly, she appears to have indicated the impropriety of the obstetrician's touch where this supplanted the mother's embodied recognition of the child through the effort of pushing it through the birth canal.

Another older, second-generation Moroccan participant recalled interventions during both her births in the following terms:

'I had an intervention with them both, so I was being fondled with so to speak, from the beginning, I wasn't allowed to... No, no, no, no' (M5.1).

Having thus presented the experience of intervention through a simile of sexual advances that were grudgingly accepted, she thus powerfully suggested how the imposition of health professionals' agency on her body served to disrupt her embodied self.

4.5.3 Protective narrative strategies and the loss of agency

Yemeni and Moroccan participants who did not have sufficient English to communicate with health professionals sought to re-cast their experiences of passivity during birth within the accounts they provided in their interviews. In this way, an older, Yemeni participant from Sa'dah, who spoke limited English (Y1), described how, during her first labour in a London maternity hospital she had sought to avoid questioning the necessity of the obstetrician's decision to use forceps to deliver the baby. The participant explained that she, 'couldn't ask' for information on her progress since imagined she would, 'ask the wrong thing' (Y1.2). She also described how she had previously dismissed knowledge passed on in storytelling since she had reasoned, 'that was just the women' (Y1.2). The participant recalled that she had been, 'lonely' and, 'ashamed' of her lack of knowledge during birth and addressed herself in the following terms:

'... what a stupid woman. She doesn't know how to have her own baby' (Y1.2).

In this way, the participant appears to have understood that her inability to trust knowledge circulated through storytelling also disabled her from seeking maternity information. In both cases, she considered her inability to understand her embodied state as having been shameful. Through the reference to her loneliness during birth, and her, 'stupid' inability to understand

her embodiment, she may also have suggested that her inability to use storytelling to understand her embodiment also prevented her from establishing relations of cultural belonging with other Yemeni women (4.2.2). The effects of this cycle of perceived *in-competent* maternal practices emerged more clearly from the succeeding story. Within this account, the participant described how she had suffered severe complications while giving birth in Yemen (Y1.3). She described how, subsequently she needed to give birth by Caesarean section. Having been asked if she eventually informed health professionals that she would need an emergency intervention during her first labour in London, she described how, 'they decided that on their own' (Y1.3). The participant reflected further on her decision not to inform health professionals of her need for intervention, and explained:

'... my main duty was to be calm for the baby. You just need to stay as calm as you can - for your child' (Y1.3).

In this way, within the first account the participant represented herself as having failed to relate her embodiment to *resilient* conceptions of the maternal body. Nonetheless, within the second account, she appears to have authenticated her passivity through an appeal to an imperative to, 'calm'. While this conception of, 'calm' appears to have derived from the imperative to protect the physical-psychic equilibrium of the mother and child, having advocated that women withdraw their maternal agency the participant appears to have fundamentally modified conceptions of the *resilient* symbolic body from the perspective of her powerless position in NHS maternity services.

A younger, Moroccan migrant participant from the region of Agadir (M4), who also spoke limited English at the time of the birth she recounted, deployed a similar narrative strategy (M4.2). The participant recounted the death of her child due an error committed by an obstetrician. Nonetheless, despite having a, 'certificate' from Morocco that, 'proved' she could not deliver vaginally, she represented herself as having voluntarily abdicated her maternal agency to him. The participant's use of the passive voice appears to have served to obscure her agency in the events that led to the birth. Accordingly, she described how:

'... when the time came, the Caesarean was opening inside... I was taken, really fast ... in the ambulance' (M4.2).

She explained that at an unknown time of day, 'they came to get me, the nurses' (M4.2). The participant remembered nothing following the onset of labour and described how, having regained consciousness, 'wired up' and, 'in emergency', she had reasoned:

'I couldn't do anything so I tried not to think about it – to make it better for the baby' (M4.2).

In this way, the account structured the experience so that the issues of authority and powerlessness that may have defined the encounter receded prior to the point at which the participant might have contradicted the obstetrician. Thus, having arrived at the point at which her agency might have been crucial, the participant explained that she chose to remain passive in order to protect her child. By reference to an imperative to, 'calm', she thus reconfigured this dangerously limiting condition as having represented a potential benefit to her child. The participant's account valorised the inverse of the values of maternal *resilience*. Nonetheless, given the disparity in authority between herself and those providing her care, the selective deployment of the principle of maternal equilibrium, may be perceived within this context, as having been liberating. In common with the account discussed above (Y1.3), this strategy served to indicate how individual participants constructed symbolic maternal bodies in order to reconfigure their experiences within specific relations of power. The positional nature of participants' constructions of the symbolic body will be discussed at length below (4.7; 6.2; 6.5).

4.6 The uses of embodied knowledge and maternity information in narrating maternal competencies

This section examines Moroccan, Yemeni and Iraqi participants' accounts of the use of various forms of maternity knowledge and traces how these practices related to symbolic notions of the body. The first sub-section (4.6.1), further explores ways in which Yemeni and Moroccan participants constructed *resilient* bodies through the use of embodied knowledge of pregnancy and birth. Where participants in these groups used maternity information, the sub-section explores the ways in which they accommodated biomedical models of the body within notions of maternal *resilience*. Within the second sub-section (4.6.2), Iraqi participants' accounts of their uses of visual information are discussed as these were seen to offer a means of constructing models of the maternal body that were animated by willed agency. Finally, in the third sub-section (4.6.3), aspects of the storytelling context in the Arab world are considered as these were described by participants across national groups.

4.6.1 Maternity information and the negotiation of maternal competencies

As Moroccan and Yemeni participants constructed ties to the homeland through notions of the *resilient* maternal body, so participants in these groups valorised labour pain as a form of embodied knowledge of birth. An example of the use of suffering as a form of legitimate knowledge of the body was provided by an older, Yemeni participant from San'a (Y2). Having reflected that the pain relief urged on her was, 'useful but also very strange', she implied the inappropriateness of her physically numb state. The participant further recounted how her anaesthetised state led to her being unaware of the moment, 'when the baby came out.' She continued to demand:

'... if something went wrong, how would you feel that you were talking and laughing away when your baby might be in trouble?' (Y2.2).

Hence, the participant perceived that the lack of sensation that followed from taking pain relief to entail her withdrawal of her personal agency in her birth. Similarly, during the focus group interview, an older, Yemeni participant from Sa'dah (YFG6), recounted how her cousin, who took gas, 'didn't know what was happening' during her labour. The participant described this loss of maternal sensation as having been, 'not nice'(YFG4.6).

As users of NHS maternity services Yemeni and Moroccan participants nonetheless widely used maternity information during pregnancy and birth. Highly moderated patterns of the use of maternity information were suggested by the account of a Moroccan, early migrant participant (M8). This account appears to have indicated broader patterns of using information to project into future events among this group. Having described how, during her first labour, she had sought information from health professionals, whom she considered, 'of course...don't know really', she explained how she projected through the events of birth using obstetric predictions:

'... each time she [the midwife] told me different, I cut up the labour into different parts... the four hours until I was open' (M8.5).

The participant was thus sceptical of the claims to truth made by health professionals in providing information to women. Nonetheless, having used medical information to project herself out of her embodied experience, she appears to have imagined her labour as having been a process that was subject to her controlling intellect. A similar pattern emerged from the

account of a younger, Yemeni participant from Sa'dah (Y4), who sought maternity information in order to understand, 'how I was changing' (Y4.1). She continued to explain:

' I wanted to know to see if everything was normal and to avoid any bad thing. For example, if I had that [high blood pressure], I would take less exercise but if I didn't I would do all the things that felt comfortable' (Y4.1)

Having indicated that behaviours might not be experienced as uncomfortable while at the same time they might harm the foetus, the participant's perception of her embodiment of the child appears to have been modified by her use of maternity information provided in the 'precautionary mode'. Thus, in common with the participant whose account is discussed above (M8.5), through using maternity information, the participant reproduced models of the surveillance of the feminine reproductive body on which the, 'precautionary mode' of information-giving has been suggested to be based (2.3.3). These notions of the surveillance of the feminine body may function in tandem with constructions of feminine agency as being founded through the control of feminine embodiment (1.4.2; 1.4.3). Within the accounts of Moroccan and Yemeni participants, the body-mind distinction emerged where participants sought maternity information to counter the potentially treacherous knowledge offered by embodiment. Nonetheless, within these accounts, participants continued to reference notions of maternal embodied agency. Participants also indicated that their uses of information served to configure links to the *resilient* symbolic body. Accordingly, an older, Yemeni participant (Y2), from San'a who had remarked that, 'a mother always has to be strong' (Y2.2), advised that in approaching motherhood:

'... you should think very much [about] how your life will change after... but you probably know once your body begins to change – I think when you're getting different, you accept a lot' (Y2.2)

Hence, the participant imagined that the embodied changes of pregnancy inevitably served to prompt an awareness of *resilient* ('strong'), motherhood. Nonetheless, having referred to her desire to imaginatively project through pregnancy, she remarked that:

'I wanted to know what was going to happen to me the whole way through. Because even then you are the mother. It is your work to know how to give birth, to know how to do it safely... and you need to think about how you will be after' (Y2.2).

Having located her agency within her embodiment ('what was going to happen to me'), the participant legitimised her action of seeking maternity information through suggesting that she used it prepare to take on a maternal role. Additionally, as she emphasised that she

intended to use biomedical knowledge to understand her embodied state during birth rather than to project through it, she appears to have sought maternity information to consolidate her perception of the *resilient* body. Similarly, having compared the act of giving birth to physical work that needs to be accomplished safely, the participant appears to have drawn on rural, working-class contexts that participants' constructions of the *resilient* body served to reproduce. Nonetheless, having envisaged that she would use maternity information to manage her own birth, the participant's use of maternity information appears to have shared important similarities with the model of *responsible* motherhood described by the Iraqi group.

A similar pattern of reconfiguring maternal *resilience* was suggested by the account of an educated, second-generation Moroccan participant (M10). The participant recounted how by checking her progress through pregnancy against a chart she was able to, 'feel confident that throughout my birth is going to be good' (M10.1). Accordingly, she indicated that maternity information provided to enable women to compare their own embodied progress against a biomedical norm also served to promote her sense of mind-body equilibrium (4.3.1; 4.3.2; 4.3.3). Other Moroccan participants who described having sought maternity information on their embodied progress also recounted how they deployed this to identify with aspects of the *resilient* body. As such, in recounting how she used a book on physiology to, 'understand' the experience of labour pain that she had already, 'accepted' (M3.8), an older early, migrant participant from the Anti-Atlas region, drew on biomedical knowledge to support a cultural perception of the beneficent nature of labour pain (4.3.4). Similarly, a younger second-generation participant (M9), advised hypothetical peers to take, 'all the tests to be done... to be emotionally ready' (M9.1). The participant immediately followed this comment with the injunction that, 'you have to accept the baby' (M9.1). She thus appears to have advocated that women used maternity information to project into motherhood in order to adapt to radical changes in women's sense of self that she, in common with other Moroccan and Yemeni participants, imagined to be entailed by entering motherhood. The participant thus used maternity information that other participants considered to be naturally and culturally dangerous. Nonetheless, she appears to have deployed this information to consolidate her links to a *resilient* symbolic body that was constructed from her particular position as a first-time mother using NHS maternity services.

4.6.2 The uses of visual images to support maternal responsibility

In contrast to the individual strategies that Moroccan and Yemeni participants undertook to accommodate biomedical knowledge and the *resilient* body accounts of the use of maternity information provided by Iraqi participants were highly cohesive. Participants in the Iraqi group used visual knowledge of the body to support their adoption of a maternal role that was

configured around, 'Islamic' injunctions on women to ensure the social and religious instruction of their children. The account of an older Iraqi participant who was a former doctor (IFG3), illustrated how Iraqi participants privileged scanned images over other sources of maternity knowledge. Appearing to have represented the foetus as having a continuous existence with that of the mother, the participant recalled the effects of looking at diagrams of blood flow to the womb during her first pregnancy. She explained:

'... when I saw how she would get everything I ate, I changed what I ate, I spent more time choosing and [as] for smoking – I didn't go to any of the student places where they smoke' (IFG.6.3).

Hence, following her realisation of the continuity between herself and the foetus, she consciously modified her diet and lifestyle to control substances entering the womb. Nonetheless, having referred more generally to the effects of visual information, the same participant recounted:

'I would see how close I was to the baby so I could do nothing to hurt it. Even before it is born' (IFG.6.3).

In this way, having imagined the foetus as being in proximity to her – rather than being embodied in her - the participant appears to have ascribed to it a distinct status to which she imagined her obligations of care to have attached. Similarly, in describing the definitive importance of her first scan, an older Iraqi participant from the Al-Qadisya district of Baghdad (I6), recounted that:

'... you couldn't take risks if you wanted to because you've seen this child and you don't have a right to hurt it' (I6.3).

Having appeared to construct her maternal behaviour around a perception of rights, the participant thus suggested that value of the scanned image as a means of projecting maternal *competencies* lay in its depiction of the distinct existence of the foetus. In this way, when prompted to consider the traditional Islamic prohibition on visual images, and the Qur'ān-ic metaphor of generation as a mystical process protected by, 'seven veils of darkness', the participant described the meanings she derived from the scanned image. She thus explained that:

'... the scan doesn't make it less special. It gives you the sense of knowing what's inside so you can imagine how it's growing... to get ready for being a mother, I think it's really valuable to see the baby like that. Just because you see it as different' (I6.3).

The position the participant had adopted on the question of the prohibition of visual images thus remained unclear. Nonetheless, she clearly indicated that, through depicting the difference represented by the foetus, looking at scanned images represented a realisation of motherhood equally as valuable as that suggested by the continuous embodiment of the foetus wrapped in, 'seven veils of darkness'. Having proposed that visual information represented a means by which motherhood might be revealed as a relationship between two distinct entities, the participant also voiced a view shared among other Iraqi participants.

A younger Iraqi participant from the Al-Rashid district of Baghdad (I5), remarked that in entering motherhood, a woman, 'has to sacrifice a lot of things, you know, like her own self' (I5.4). The participant continued to describe how her transition to motherhood – for the second time – had been prefigured by her viewing the scanned image of her son:

'With him, it was thinking you've got another human being growing inside you, it's a very big thing and you don't realise that until you see his picture on the scan' (I5.4).

As the participant emphasised the importance of realising the distinct nature of the foetus as, 'a very big thing' (I5.4), she appears to have sought to obscure her own physical agency in its growth. Accordingly, she rejected a prompt to consider her embodied knowledge of the foetus' growth. In contrast, she described her relationship to the embodied foetus in terms of her exercise of projecting a visual form onto it, having explained:

'... day by day you expect that this bit [makes mime of hand] or that bit of his body is growing and you think that's another responsibility' (I5.4).

Since she represented the foetus as having an existence separate to her embodied self, so she was also to construct her relationship to it as involving, 'responsibility'. Thus, while she did not suggest that her embodiment of the foetus was hazardous in itself, as was the case in the account discussed above (I6.3), her account of adopting the model of motherhood configured around *responsibility* entailed acts of willed agency ('expect...think'), that served to control her body.

The use of maternity information in the form of scanned images appears to have been fundamental to Iraqi participants' constructions of motherhood as these served to retrieve the

embodied foetus from its embodied position in the mother and to produce it as the future object of maternal instruction.

4.6.3 Social sanctions on the use of oral knowledge

While participants' uses of legitimate knowledge of the maternal body related to their imagined relationships of belonging in migration, patterns in the use of maternity storytelling were also complicated by social sanctions against peer advice that are prevalent in much of the Arab world. In this way, participants across groups prefigured their accounts of using storytelling knowledge with the adage that birthing accounts were specific to the teller. Nonetheless, the uses to which this caveat was put varied across participant groups. An account provided by an older, second-generation Moroccan participant (M6), provided an example illustrating the most common use of this axiom. Having described how her mother's accounts of giving birth in Morocco offered her the, 'comfort' derived from being at, 'home', she nonetheless advised that, 'you've got to think maybe mine's not going to be like yours' (M6.6). Similarly, a Moroccan, early migrant participant from the Anti-Atlas region (M3), recounted how she and her friends were, 'talking and laughing,' immediately before the interview when considering differences in their experiences of birth. The participant emphasised that sharing such accounts served to enable pregnant women to be, 'prepared for any way it comes' (M3.7). Hence, the axiom functioned to support maternal equilibrium by warning women against projecting into birth events and by emphasising the contingent nature of birth.

In contrast, Iraqi participants used the same adage to emphasise the individual character of each mother's experience of birth. Accordingly, having remarked that, 'every woman thinks about pregnancy from her point of view' (I6.5), an older Iraqi participant from the Al-Qadisya district of Baghdad (I6), continued to describe how women listened to narratives of birth in order to, 'look for the differences... then you have a different story' (I6.5).

A further dimension of Arab social life that may affect women's use of different forms of maternity knowledge is the popular belief in the, 'evil eye' as a means through which to harm infants through cursing them with a glance. In this way, an older, Iraqi participant from the Al-Mansur district of Baghdad (I3), who gave birth to twins at a relatively advanced age, described how she perceived that, 'sometimes people feel jealous that I have two' (I3.7). She continued to demand, 'you know about the evil eye?'. As such, she appears to have sought to explain her perception of the potential harm posed to her children by their visibility to women from outside the family through this indirect reference to the belief. The power that was

indirectly attributed to the evil eye, thus contributed to her disinclination to discuss the birth of her children outside her family (4.4.4).

4.7 Conclusions

This chapter has illustrated how individual Moroccan, Yemeni and Iraqi participants used knowledge of the body to invest their embodiment with cultural meanings. The choice of the forms of knowledge that participants thus considered to be legitimate was determined by their constructions of symbolic maternal bodies that reflected perceptions of femininity in the homeland. Moroccan and Yemeni participants sought to configure links to, 'vernacular' perceptions of femininity. Accordingly, these groups conceived of storytelling accounts and their own embodied sensation as forms of legitimate knowledge. The storytelling accounts discussed by these participants associated embodied knowledge of motherhood with women's manual work. They also related women's embodied knowledge to perceptions of the continuum of the physical and psychic states of mother and her foetus. By drawing on these sources of legitimate knowledge, Yemeni and Moroccan participants constructed a *resilient* symbolic body that served to assert their rural and working-class identifications in migration. The findings suggested divergent patterns of imagining the homeland, the symbolic body and legitimate knowledge of the body among Iraqi participants. This group configured their maternal identities around nationalist conceptions of femininity through using maternity information and through drawing on, 'Islamic' conceptions of mother's duties to provide the social and religious education of their children. By using these sources of legitimate knowledge to privilege the mind over the body and to construct an opposition between the public and private spheres, Iraqi participants constructed a *responsible* symbolic body that appears to have reflected the post-Enlightenment conceptions of the subject discussed above (2.3.1). Through the construction of the *responsible* maternal body, Iraqi participants configured their maternal identities around memories of metropolitan localities and middle-class working and consumption practices in Iraq.

As has been suggested above (1.2; 3.4.5; 4.1), a framework of opposing categories emerged from the accounts of all participant groups and served to structure participants' relations of belonging within the information-giving encounter. These structures of opposition within the narratives of Iraqi, Yemeni and Moroccan participants were founded on the central opposition of embodied and cultural openness and closure. This section will explore the functions of two latent oppositions derived from the central opposition as groups of participants used these to produce identification and to project difference in the maternity information-giving encounter.

The biomedical body and embodiment

Yemeni and Moroccan participants perceived the use of maternity information to disable the central characteristics of the *resilient* symbolic body. In this way, information given on potential hazards during pregnancy and on the possibilities of difficult birth, foetal deformation and disease was perceived to disable women's capacities to protect their body-mind equilibrium (4.3.1). Similarly, participants perceived that information given to invite women to project out their embodied pregnant states served to obscure their embodied awareness of the foetus. The use of such knowledge was thus seen by participants to disrupt their natural-cultural transition to motherhood (4.5.1). Hence, where advice offered by health professionals led to the acceptance of pain relief or intervention, such communication was recounted as having involved coercion (4.5.2). Yemeni and Moroccan participants' investment in the understanding of embodied experience as the basis of the transition to *resilient* motherhood was further suggested where participants in these groups described experiences of undergoing intervention in terms of the violent incursion of difference into their embodied selves. Nonetheless, while participants in these groups perceived that using maternity information served to open the natural-cultural body to the cultural difference represented by the biomedical body, they widely used maternity information during pregnancy and labour. While participants who had used maternity information reproduced an objective and externalised perspective on their own embodiment, they also used such information to consolidate their embodied knowledge and to support notions of the fracture in women's sense of self entailed by entering *resilient* motherhood. Participants' constructions of the symbolic body were thus shown to be flexible. Examples of the degree to which the *resilient* body was produced situationally were suggested in the discussion of participants' strategies of legitimating states of natural-cultural openness by reference to a fictive cultural prerogative to maternal passivity (4.5.2; 4.5.3).

In contrast, Iraqi participants perceived the use of scanned images of the foetus to prefigure women's relationships with their children as these were mediated through cultural practices of instruction (4.5.2; 4.5.3; 4.6.2). Similarly, information on potential hazards to the child was used by these participants to regulate their embodiment. While these practices of the control of feminine embodiment appear to have important similarities to practices of *feminine disciplines,* in addition to the biomedical model, these were nonetheless used by participants to structure symbolic bodies that enabled them to differentiate both from British society and from other Iraqi and Arab groups (see 6.2; 6.5). Iraqi participants' construction of the objectified symbolic body as a source of difference was thus analogous to that of Moroccan and Yemeni participants, among whom the opposition of embodiment and the biomedical body, appears to be strategic, positional and incomplete (6.5).

Pain and the cultural self

While experiences of migration and settlement involve a transition that is continually renegotiated in cross-cultural interaction, for most mothers, birth entails a transition that is definitive. Moroccan and Yemeni participants had permanently settled in London and thus were likely to be continually engaged in such acts of identification within British public settings. Among these groups, labour and birthing pain was perceived as a means through which women adopted a fixed cultural identity. Thus, having emphasised the disruptive potentials of pain on women's sense of an individual self, Yemeni and Moroccan participants nonetheless valorised experiences of labour pain during first labours. These participants perceived that experiences of labour pain served to indelibly mark the transition into maternal identities that were anchored in constructions of the homeland and of the past lived in the homeland (4.2.2). Through notions of the fracture in women's identities caused by entering motherhood and through notions of embodiment as a culturally legitimate form of knowledge, pain was thus transformed into a token of invigorated cultural belonging (4.3.4). Among the Iraqi group, who envisaged an imminent return to Iraq, accounts of the transgression of the body in pain were projected onto working-class and rural Iraqi women. As identifications with pain during labour and birth were associated with animal states within these accounts, these were used by Iraqi participants as inauthentic identifications against which to define their own perceptions of belonging to metropolitan settings in Iraq (see 4.4.2; 4.4.3).

While the theory of myth proposed by Lévi-Strauss maintained that cultures organise concepts through structures of opposition, it also suggested that where these structures were negotiated within an account, the opposition between these concepts was not finalised. Similarly, within the accounts that formed the, 'myths' of maternal belonging among the Iraqi, Yemeni and Moroccan participant groups, individual representations of bodily transgression served to re-establish symbolic models of the body. These symbolic bodies will be shown to provide the scope for individual participants to negotiate natural-cultural selves (see 6.4; 6.7). Participant narratives thus appear to have functioned to transform the potential of the loss of self present in the openness of the maternal body into a means to imagine new and contingent relations of cultural belonging.

Notes to Chapter 4:

[1] The defining role of breast feeding as an Islamic practice was also suggested by a number of other Yemeni and Moroccan participants (examples being in Y5.11; Y4.2; Y4.3; M5.3; M6.9; M9.4).

[2] This practice of containing cultural difference by storytelling in the home was formulated within the participant's relationship with her husband rather than within a wider social context of female relatives and friends. The private nature of the relationship was re-enforced as the participant described how she was solely responsible for the instruction of her son s as her husband 'can't do anything' related to storytelling (I5.4).

[3] Preferences for girls were linked to expectations of closeness as daughters themselves become mothers. As such a younger participant (IFG6.5), commented - to much laughter - that girls are, 'for the mother'. Similarly, another younger participant (IFG6.6) remarked that 'my mother and I are much closer after I got pregnant (IFG7.6). More widely, maternal competencies that were configured around intellectual agency appear to have functioned to privilege relationships among women in the family. Hence, an older participant described how pain represents a gift, 'you give to your child' (I7.6), and recounted how, 'if you have a girl, she will know what you suffered' as she herself becomes a mother. Nonetheless, having also explained that where a woman has a son, 'this is why your daughter-in-law must love you!'(I7.6), the construction of privileged familial relationships through the recognition of private pain was imagined as involving a debt of affection and obligation. This conception of a debt of obligation appears to reflect and to re-enforce a hierarchical - and patriarchal - family structure.

Chapter 5:

Narratives of identification and difference among London-based maternity health professionals

5.1 Introduction

This chapter will trace how professional discourses of rights, responsibilities and patient agency provided informing contexts for health professional's accounts of the information-giving encounter. The chapter will also consider the relationship of these discourses to health professionals' ways of articulating personal identity and group belonging. The second section (5.2), will explore participants' perceptions of the functions of maternity information. It will also examine representations of Black and minority ethnic women in Britain as these served to produce a single category of, 'non-White' culture. Through considering representations of willed agency, the body and the functions of storytelling among these groups, it will consider the use of categories of public and private in delimiting appropriate uses of NHS services. The third section (5.3), will describe the relationship between education, 'Western' cultural values and willed agency. Visual metaphors for medical knowledge and the figurative uses of the boundaries of the hospital space to fable identification and difference will be considered in the fourth section as these suggest patterns of producing gender and institutional identities (5.4). The following section (5.5), will explore a modified view of the functions of information in orientating towards motherhood and will raise questions concerning individual difference, cultural constructions of decision-making and the role of storytelling in conceptualising the passage to motherhood.

As was the case in the previous chapter (4), the conclusions to the findings form a series of linked oppositions. The relations of these oppositions will be discussed to suggest common

structures within which health professional participants of established and experienced identification and difference in their accounts of the information-giving encounter.

5.2 The maternal body as a site of cultural contestation

This section considers the use of discourses of rights, responsibilities and individual, willed agency in constructing the *proper* uses of maternity information and in delimiting perceptions of the appropriate uses of NHS services. The first sub-section (5.2.1), explores perceptions of the relationship of willed agency and maternal responsibility as necessary conditions for the use of information in decision-making. It also explores how the construction of a, 'non-White' female subject served to define these notions of information use. The second sub-section (5.2.2), considers representations of the feminine reproductive body, willed agency and the uses of information among these groups. Accounts of peer storytelling among Arab women and other Muslim migrant groups are discussed in the following sub-section (5.2.3). More nuanced views relating to the use of individual accounts within the natural birth movement are explored in the final sub-section (5.2.4).

5.2.1 Willed Agency, information and maternal responsibility

Discourses of rights and responsibilities that underlie practices of equality in health services have been indicated to draw on profound inequalities that structured the Enlightenment understanding of the self-responsible subject (2.3.1; 4.6.1). Women and the less educated were thus seen to be incapable of practising individual responsibilities and enjoying rights due to their identifications with the body and with the domestic sphere (2.3.2). Similarly, the cultures of colonised groups were perceived to lack notions of the public sphere in which individuals might acts as self-responsible subjects (2.3.2). Conversely, through privileging willed agency over the body, individuals were perceived to enter the public sphere where they would be accorded rights (2.3.1).

The accounts of health professional participants described a triadic relationship between notions of responsibility, individual agency and the *proper* use of maternity information. An example was provided by the account of a White, English GP, who described the function of information on types of care in terms of encouraging responsible behaviour:

'I think if you don't give good information, you're not going to get there in the sense of responsibility' (GP1.1).

The participant thus represented her practice of providing patients with maternity information to have been a precondition for their development of individual responsibility. She continued to remark that:

'... in order to have responsibility, we have to feel that we have some control over our situation and what we're doing and where we're going' (GP1.1).

In the absence of such, 'control', the participant described the patient's experience of using maternity services a metaphor of industrial production. Having imagined herself in the position of such a patient, she explained that:

'... you feel that you're just on this conveyor belt that goes on no matter what... I don't think they want to realise that it isn't a conveyor belt - that you don't have to partake in [sic] everything' (GP1.1)[1].

The participant thus censured patients whom she perceived did not seek to use maternity information to make decisions on maternity care. She continued to illustrate how she perceived patients ought to use maternity information by imagining a patient who reflected on the ratios of the potential risks and benefits of pre-natal testing. The participant returned to consider the position of patients whom she perceived to refuse to acknowledge choices within maternity services. She perceived that, seen from this perspective:

'... you don't feel that it's your responsibility... that you've handed over in some sort of passive way to health professionals' (GP1.3).

Accordingly, the participant associated patients' perceived failures to acknowledge the availability of choice with their lack of a sense of individual self-responsibility. The relation of individual responsibility and the *proper* use of maternity information was more clearly defined by participants against the perceived practices Black and minority ethnic women. As the construction of this category served to define the self-responsible actions of British, European or Anglo-American women and the institutional and gendered identities of health professionals, the category has been termed, 'non-White'. This designation was also intended to indicate the non-subject status that was thus projected onto individual women in these groups. An account provided by a male, Spanish GP (GP3), illustrated the relationship of non-responsibility, the familial sphere and the failure to make *proper* use of information. The participant recounted that Arab Muslim women represented, 'possessions' within the family. He continued to describe his perception of the effects of the organisation of Arab families on women's development of a sense of self-responsibility and maternal responsibility:

'Everything is decided for them, so how can you expect them to take responsibility for themselves? For their child? I mean in terms of being able to make decisions, they don't learn to do that' (GP3.5).

Having perceived Arab Muslim women to lack a sense of self-ownership, the participant thus viewed these groups as being unable to use willed agency in decision-making. He continued to describe his perception of the implications of the patriarchal structure of Arab families on Arab Muslim women's capacities to use maternity information by recounting how these groups would react to his attempts to invite them to imaginatively project into the later stages of their pregnancies:

'... they just go on through it. They don't want to know anything about what will happen next' (GP3.5).

In this way, the participant suggested that where women's individual, willed agency was weak, as he perceived to be the case among Arab Muslim women, women's sense of self-responsibility were underdeveloped. Consequently, he viewed Arab Muslim women to have been uninterested in decision-making. He also suggested a further important aspect of participants' perceptions of the *proper* use of information by indicating that Arab Muslim women did not seek information through which to project out of their embodiment into situations yet to arise where decisions might need to be made (5.2.2; 5.4.1).

Having described a similar set of conditions that determined women's use of maternity information, a young, female obstetrician from South Africa (OBS3), who described herself as, 'Black African', recounted that African migrant women sought to, 'block...out' information on procedures they sought to avoid (OBS3.5). The same participant recounted how two African women in London who had previously undergone Caesarean sections refused to have subsequent interventions. She described their actions as having been motivated by their fear of being subjected to, 'stick' from, 'their community' (OBS3.5). She continued to consider the scope of African women's choices during labour and concluded that:

'African women don't want information... they have to go through labour because their community makes them feel that this is something they're going to have to experience at some point in their life' (OBS3.5).

She thus assumed that African migrant patients universally abandoned their individual agency to the collective and homogenous will of, 'the community'. The participant provided a further

example to illustrate her perception of the relationship between, 'non-White' culture and feminine agency. She described how an African and a, 'British' woman who had previously suffered sexually transmitted infections were given the choice of vaginal delivery or of an elective caesarean section. She imagined the African woman who was, 'influenced by culture,' to affirm, 'I'd like to try for a vaginal delivery' (OBS3.5). She contrasted this choice with that of the, 'British' woman. The participant imagined that this woman's choice had been, 'based on information' (OBS3.5). Having continued to recount how choices based on cultural priorities were, 'as valid' as those based on information found, 'on the internet', the participant explained that, 'everybody gets coerced but on different levels' (OBS3.5). Nonetheless, with regard to, 'this... choice based on culture', she reflected that, 'they do sometimes take it too far' (OBS3.5). Having thus appeared to suggest that the limitations African, 'culture' placed on women's use of maternity information also placed a strain on the provision of maternity services, the participant switched the focus of her account to consider Iranian patients. The participant stated that women in these groups, 'don't want no doctor, no one to do an internal on them' (OBS3.5). Having conflated these entirely different societies within a single notion of, 'culture' the participant appears to have emphasised the common invalidity of the choices of women in these groups. By associating the choices of Iranian women with the African women whose, 'cultural' choices were perceived to abuse NHS services, the participant appear to have indicated that Iranian culture similarly disrupted the provision of maternity services. The participant thus collapsed notions of the two cultures, however her description of the inaccessibility of the bodies of Iranian women and their opacity to the medical gaze, represented the disruptive cultural difference of a specifically Muslim group. These characteristics will be discussed in detail below as they were used by health professionals to justify their withdrawal from the provision of equitable care (5.2.2; 5.4.1; 5.4.2). Having continued to consider the relationship of culture to the use of information among Iranian women, the participant remarked that:

'... they don't see things clearly... theirs isn't a well-informed choice - theirs is a choice because of their culture. Because their mother did it this way, way back in a third-world country, this is the system' (OBS3.5).

In this way, the participant viewed the preferences of African and Iranian women for unassisted delivery to have been produced inside a cultural code that was monolithic and with which the women did not engage. Additionally, the participant represented the appropriate uses of maternity information in terms of its function in enabling women to project out of their current embodiment into future events. In common with the participant whose account was discussed above (5.2.1), the participant thus appears to have perceived the proper use of

maternity information to serve to replace women's embodied position with their projection in time into future acts of decision making to be exercised on the body. Conversely, she suggested that the rejection of such a perspective by African and Iranian women who derived from a desire to reproduce experiences, 'way back' in the family homeland. By seeking to reproduce experiences that were distant from their current position in both space and time ('way back'), the participant appears to have suggested that African and Iranian women's identifications with tradition and with their homelands served to shorten their temporal perspective. The participant's view thus recalls perceptions of the a-historical nature of native societies that was used to represent colonial expansion as offering progress to colonised groups (1.3.2; 1.6.1 – 1.6.5).

5.2.2 'Culture', agency and the feminine reproductive body

The problematic status of the feminine reproductive body in models of the self-responsible agent have been discussed above (1.4.1; 2.3.3). Similar perceptions of the treacherous nature of identifications with feminine embodiment informed health professional participants' conceptions of individual feminine agency in decision-making. Accordingly participants perceived that the inappropriate uses of maternity services derived from identifications with the feminine reproductive body. An example that suggests the disruptive potentials of such identifications in using maternity information and in making appropriate use of NHS maternity care was provided by the account of a young, Spanish GP (GP3), whose earlier perceptions of Arab Muslim women were considered above (5.2.1). Having recounted that rural, less-educated Arab Muslim women were not, 'interested in choice', he described how:

'I don't think they care even to know if they're sick. It's shame... they're ashamed of their bodies... you can see that. They wear loose black clothes so no one can see them. It's like they are lost inside those things... You can see they effects of that on them clearly. They breast feed for so long, because they are expected to and their breasts are really low – sagging because they continue doing this – although they don't need to for err... nutrition' (GP3.4).

In contrast, the participant recounted that in Spain, women had taken to dyeing their hair blond and styling it, 'like boys'. This group of Spanish women was also said to have, 'taken up their place in society', and to have, 'left the house' (GP3.4). Accordingly, the participant appears to have associated women's participation in the public sphere of work to have resulted from women's freedom to impose *feminine disciplines* on their bodies. Conversely, having described how Arab men forbade their wives to be examined by him, the participant suggested that the, 'problem of sex is in their heads' (GP3.4). He thus appears to have indicated that Arab Muslim women's failure to regulate their embodiment had implications on

the behaviour of Arab men within the public sphere of NHS health services. Having recounted how these groups, 'bring their ideas into the surgery', he thus appears to have suggested that women's identifications with their maternal embodiment served to obscure the boundary between public and private spheres among poorer Arab Muslim groups at large. The participant referred to his training and his provision of a free service as factors exacerbating the affront caused him by perceptions he sought to, 'touch some old man's wife' (GP3.4). Thus, through representing the failure of Arab Muslim women to adopt practices of controlling their reproductive bodies and through the associated suggestion that these women lacked agency within their family relationships, the participant indicated that the familial sphere transgressed the public space of the NHS. Through these actions, the participant represented the demands for appropriate care of poorer, less-educated Arab Muslim migrants as serving to abuse the publicly-funded basis of the NHS.

The participant's view of the disruptive potentials of maternal embodiment on the provision of NHS maternity services was shared more widely among participants. Accordingly, in considering why, 'Asian' women did not seek maternity information, the young, obstetrician participant whose perceptions of culture and decision-making were discussed above (OBS3), explained that:

'They don't choose when they get married. So when they get married, whenever, they have sex... If you don't take any contraception, you go off and you have sex, you become pregnant. It's a consequence of being married. But... yeah... if you don't choose when you get married... if you don't prepare yourself to be pregnant, why would you prepare yourself to be a mother? If you don't want to go forward, if it's just something that happens, then you might want to be left in the dark...' (OBS3.15).

The participant thus perceived that, 'Asian' women lacked choice in decisions on their marriage partners. She also perceived that this group failed to regulate their fertility. Taken together the participant perceived that these characteristics limited the capacities of, 'Asian' women to use information to project through the pregnancy and to make decisions on the care of their children. The participants thus linked the perceived refusal of, 'non-White' women to control the body with the inability of these groups to use vision to project actions in the future. As was suggested above (5.2.1), the participant thus contrasted women's embodied positions with the objectified view of the body and its progress that she associated with maternity information.

The participant continued to emphasise the relationship between women's contraceptive practices and their wider capacities to control their bodies. As such, she demanded:

'... how many Muslim couples have you come across who would say, 'oh we're not going to have kids for another five years'? It just doesn't happen. How many Muslim couples do you see in antenatal classes? How many Muslim women worry about stretch marks [laughs]?... You know rubbing the oil on the stretch marks...?' (OBS3.15).

As the participant viewed the practice of *feminine discipline* as being a necessary condition for women's contribution to shared decision-making, so she appears to have perceived women's identifications with the body as belonging to the private sphere. Accordingly, having continued to refer to Muslim women, the participant asked:

'Do they exercise after the birth? You don't know, you just.. .you just don't see them afterwards. They just disappear back into the community and according to them, they're going to learn the skills of motherhood from their mother-in-law' (OBS3.15).

By collapsing notions of exercise classes with courses teaching mothering skills, the participant suggested that practices of shaping and beautifying the maternal body underlay women's participation in post-natal maternity services as a whole. Having possibly reflected a similar perception of the control of the feminine body as a means to gain access to the public sphere, the participant appears to have sanctioned, 'Muslim' women's identifications with the body and the private sphere through her figurative use of, 'back' ('back into the community'), that appears to have implied the retrograde nature of this step. Similarly, the spatial suggestions of women's return, 'into' the community implied that the Muslim social networks represented a dense mass in which women were lost from the participant's view.

Within a later account, the same participant explored issues of maternal agency and the body among, 'first-world' women and among women from Black and minority ethnic groups. Having been prompted to consider that choices for natural birth among all groups of women stemmed from similar perceptions of motherhood, the participant explained that:

'For your first-world women, being a mother isn't just pushing it [the baby] out. To them it's a whole thing of nurturing the child... because they nurture their bodies and therefore they consider they should nurture their child afterwards. But they [pause]... they anticipate a lot of the child's needs I mean they, they when they're in labour, they would have got the clothes ready...the cot ready, you know... they would have chosen the name... they would have made a lot of plans for this baby [pause]... (OBS3.13).

As such, the participant conceptualised maternal agency through the *discipline* of the feminine body. In this way, the participant disassociated notions of 'nurturing the child' from

its physical sense of feeding the child. In contrast to the sense of physical nurturance, the participant used the phrase to describe women's practices of, 'nurturing' the body, that were described elsewhere in the same account as involving, 'working out' and, 'taking care' of one's figure (OBS.13). Once again, a participant appears to have imagined the *proper* use of information both to serve to control women's embodiment and to entail women's imaginative projection in time. Accordingly, the participant imagined responsible pregnant women to prepare the nursery, to chose the child's name and to have envisaged it as a separate entity after birth. By envisioning the importance of projecting out of pregnant embodiment and into an individual relationship with the child, the participant thus described a cultural view of motherhood that recalls the Iraqi participants' perceptions of, 'Islamic' motherhood (4.4.2; 4.6.2). Having continued to contrast this perspective of motherhood with that of women from Black and minority ethnic groups, the participant described how:

'... for them [first-world women] it's the biggest thing of their life and it's the biggest thing of their individual life and then that's the difference between your other women, your ethnic minority women. To them this is simply a life event in the context of their community...' (OBS3.13).

The participant thus understood individual feminine agency to have rested on the distinction between the public and the private sphere. In the absence of women's practices of diet and exercise, she imagined that this distinction between the public and private spheres broke down. Accordingly, she perceived that the communal meanings of birth served to displace the mother's ownership of the event. The participant perceived that minority ethnic women universally brought cultural meanings to bear on their experiences of birth. Through these meanings that rendered experiences of birth meaningful as a, 'life-event' in the 'context' of the group, she suggested that women's individual responsibility for the event experience was lost. She viewed the same cultural understanding of birth as serving serve to prevent pregnant women from projecting out of their embodiment and into an individual relationship with the child.

An older, White English GP (GP2), deployed notions of the opposition of feminine agency and the feminine reproductive body to suggest a more personal identification. Having maintained that the condition of Arab Muslim mothers whose children are approaching adulthood was, 'frightening', she explained that:

'They just seem to have nothing left in their lives. I can't tell you, loads and loads of middle-aged, depressed Muslim women – over- weight, all sort of [laughs] very over-weight with osteo-arthritus of

their knees... There are patients the same age as me who've had five or six kids who look fifteen or twenty years older than me and they feel it as well' (GP2.10).

As the participant perceived Arab Muslim women to have over-invested in motherhood, so their bodies were described as, 'depleted', obese and diseased. Conversely, in comparing her physical condition with that of a hypothetical Arab Muslim mother, the participant emphasised her youthfulness and her slim figure in addition to referencing her good state of health. She may thus have suggested her own investment in practices of controlling her maternal body. Having described how Arab Muslim women married young at the instigation of their mothers, the participant referred to, 'a lack of choice' among this group. She continued to outline her view that Arab Muslim mothers' practice of choosing their daughters' marriage partners fundamentally limited their daughters' capacities to exercise individual agency in using NHS maternity services:

'You see it in pregnancy, you want them to take control but they just don't understand – they don't have the responsibility' (GP2.10).

Having thus perceived Arab Muslim women to lack agency over their bodies and to be prevented from selecting a marriage partner, the participant viewed individuals within this group were viewed as being unable to adopt the status of active agents in making choices regarding their maternity care.

5.2.3 Storytelling as a culturally normative practice

The values that health professional participants ascribed to their patients' practices of maternity storytelling appear to have represented an important dimension of the cultural environment in which their practices of information-provision took place. Given their perceptions of the relationship of agency, responsibility and the use of information, and their constructions of, 'non-White culture, storytelling among women from Black and minority ethnic groups was perceived to have damaging effects on the ability of women from these groups to make choices on maternity care. Accordingly, a younger, White, English obstetrician (OBS1), who explained that in the case of, 'Asians, Africans and your group' the ideal of, 'real motherhood' was determined by practices derived, 'from their families, from their culture' (OBS1.5). The participant continued to describe how women in these groups sought to identify with social conceptions of motherhood. Thus, she described how:

'An awful lot of what women go through - or what women want - is from what they're told, from the way they're brought up and what other women - friends, sisters - have said about the way they did it' (OBS1.5).

Having confused the metaphors of, 'coming from' a certain background with, 'coming to' a conclusion, the participant may also have implied that women from Black and minority ethnic groups would inevitability seek to reproduce the birth experiences of women whose accounts they had heard. Similarly, in a later account (OBS1.7), the participant described how the, 'previous ancestors,' (mothers and grandmothers) of women in these groups would have had no choice other than to deliver without intervention. The participant's use of the term, 'ancestors' may have reflected her perception of the anthropological nature of the research. Nonetheless, it also appears to have indicated her belief in the primordial nature of the preferences of women from Black and minority ethnic groups for natural birth.

A young, South African obstetrician (OBS3), further indicated participants' perceptions that maternity storytelling among, 'third-world' women served a normative function. The participant provided a hypothetical account of two women who had undergone Caesarean sections and who both refused a third. She described the first woman who as being, 'well-educated' and explained that she carried, 'sheaves and sheaves of paper' that informed her of the risks of uterine rupture entailed in seeking a natural birth. The participant contrasted this woman's behaviour with that of a woman, 'from North Africa, somewhere' as she continued to recount:

'In one case, knowledge influences a woman... and she quoted the figures - and the figures were horrendous but she said, 'well, I'll be the one in a thousand who doesn't rupture my uterus'. The other woman had no figures but she was influenced by her community... women telling all about how they went through it. So that's what she wanted' (OBS3.6).

In this way, the participant represented the use of information in decision-making as a practice that enabled the second woman to take responsibility for her choice to seek an unassisted delivery. In contrast, she perceived the second woman's use of maternity accounts as a behaviour that was motivated by the woman's desire to conform to the cultural norms of the migrant group in London. Having been invited to consider whether influences exercised by, 'the community' and maternity information did not represent different types of knowledge on which to base a choice, the participant described how cultural exemplars were:

'... not well-recorded because these experiences come from a community that was reared in a non-Western culture' (OBS3.6).

Having referred to modes of organising experience in North African societies, the participant thus suggested that the non-empirical basis of storytelling served to limit women's capacities to make choices concerning their maternity care. As appears to have been the case above, in the confusion of, 'coming from' a community and, 'coming to' a conclusion, the confusion of, 'women' and, 'community' suggests the participant's perception of the interchangeable nature of the minority group and the individual selves of which it was composed. The participant continued to recount how an, 'African woman' who had previously undergone two Caesarean sections, 'in a third-world hospital' refused advice to undergo an intervention based on the accounts, 'of an aunt' (OBS3.6). The participant continued to explain that the woman in question:

'... she is basing her knowledge on a third-world woman living in a third-world community where there are very few women walking around with who've lived to tell the tale' (OBS3.6).

Owing to a lack of awareness of the different contexts of, 'first-world' and, 'third-world' medicine, the participant perceived that the use of familial storytelling posed a danger to African migrant women. Accordingly, she suggested accounts of maternity experiences shared among these groups functioned to desensitise African migrant women to information that health professionals provided them in order to enjoin on them responsible maternal behaviour. Additionally, the participant's criticism of the woman's use of stories provided by, 'an aunt' indicated that she perceived maternity storytelling among African migrant women to serve to introduce the familial sphere into the public provision of maternity services. This account thus appears to have reflected that reported above that suggested that identifications with the body among poorer, less-educated Arab Muslim groups served to undermine the basis of the medical encounter in the British public sphere(5.2.2).

A further criticism of practices of maternity storytelling suggested by participants related the perceived use of accounts of birth by non-English speaking, migrant women to arouse the fear of their pregnant co-migrants. A young, first-generation, Jamaican midwife (MD1), provided examples of putative accounts that distressed her clients who did not, 'have much English' (MD1.1). She explained that these stories recounted events such as, 'she tore from front to back', 'they had to take her to the pit' and, 'she was only 5ft and her baby was 20lbs' (MD1.1). Having described the operating theatre as the, 'pit' to which birthing women were taken, she may also have implied that these accounts functioned as a form of imaginative trial

prior to that of labour itself. Less ambiguously, the participant also suggested that, having listened to such accounts, her pregnant, migrant patients were, 'paralysed' by fear.

An older, White English GP shared the perception of maternity storytelling as a form of trial that women from Black and minority ethnic groups practised on other women in the migrant group (GP2). Having described how young, 'Asian' women suffered, 'bullying' within matriarchal family hierarchies, the participant suggested that, for older women in these families, storytelling represented:

'... a case of enjoying the power they have over the younger ones' (GP2.6).

The participant continued to describe how storytelling in Asian families entailed passing on fantasies of suffering. Accordingly, women were imagined to recount the birth of, 'impossibly large babies' and to dwell on experiences of, 'horrendous tears and....later incontinence' (GP2.6). Hence, in describing transgression, such stories suggested that the stress of birth entailed the permanent loss of bodily boundaries. The participant's reference to, 'all that sweat' indicated that she perceived that accounts of birth passed on in, 'Asian' families centred on physical effort. However, having imagined that such accounts contained, 'real slaughter-house' description and suggested to the listener, 'the possibility that she'll die', the participant also appears to have perceived that maternity storytelling in, 'Asian' families posed dangers to women's sense of self (GP2.6). Given that the participant suggested that these narratives abandoned the figure of the birthing woman prior to the moment of birth, she appears to have implied that these accounts served solely to emphasise women's experience of pain (6.3; 6.4).

Having continued to refer to exaggerated birthing accounts, the participant considered how these influenced women's capacities for planning later events in pregnancy and birth:

'They scare them to death... they can't plan ahead at all... Every time I see them later on [in pregnancy] it's about calming them down enough so that they can take in what you say'' (GP2.6).

As such, practices of recounting the transgression of the body in birth, were suggested to disable Asian women from the use of information to project through embodiment and to make choices on medical care.

5.2.4 Essentialism and 'choice' – the Natural Childbirth Movement

The culturally and racially specific nature of participant's constructions of maternity storytelling among women from Black and minority ethnic groups, was suggested by participants' treatment of accounts produced by the natural birth movement. Accordingly, an older, English GP (GP2), recounted that within a, 'White, middle-class,' group, the experience of labour pain was sought as it was seen to represent a, 'proof of womanhood' (GP2.7). Despite having appeared to describe the use of labour pain as a normative identification within accounts produced by the natural birth movement, the participant suggested that these also related to other discourses of femininity:

'... they will tell you that it was this wonderful experience because I was strong and I took yeah... control' (GP2.7).

Hence, the participant perceived that accounts advocating minimal intervention that were used by middle-class, White women represented women's transition to motherhood as being achieved through women's practices of willed agency over their bodies. The participant continued to explore the motivations that led women to identify with these models of femininity:

'... you get your buzz. But really it's about being a real woman. The truth is very few are in that way – and maybe that's its appeal for some' (GP2.7).

In this way, the participant suggested that the ideal of authentic femininity that was described in these accounts was fundamentally informed by notions of competitiveness.

Having suggested a similar perception of the normative functions of birth narratives provided by British advocates of natural birth, an older, English obstetrician (OBS2), refuted suggestions of, 'magical, orgasmic experiences' of birth that she perceived as being made by these accounts. She remarked that women who had used such accounts to prepare for birth were, 'often very surprised' by their own experience of labour pain (OBS2.11). Having rolled her eyes and laughingly stated that, 'the process is not what I'd call orgasmic' (OBS2.11), she sought to burlesque the claims of essential femininity that she perceived to be made by advocates of natural birth by deftly drawing on her own maternal and feminine experience.

An older, White, English GP (GP4), suggested a more extensive critique of the construction of authentic feminine identity in the literature of the British natural childbirth movement.

Having described how White, British women considered birth to represent a struggle to be fought against medical intervention, the participant recounted that :

'... what I really dislike is the idea that you're not a true woman if you don't have a natural delivery. I think that the really damaging thing is that now in British society pain relief is always seen as a failure. Have you read that terrible book[2]....? Well they read it, all these White, first-time mothers and they come in thinking that they have to fight the doctor' (GP4.7).

The participant thus suggested that, having used accounts that valorised labour pain as a key experience in establishing their gender identity to understand the transition to motherhood, White, British women necessarily sought to postpone necessary interventions. She continued to describe how a, 'White, well-to-do' patient who had used British accounts of natural birth chose to continue an unassisted delivery against medical advice. The participant explained that the woman's decision led to the birth of her child with a, 'severe handicap' (GP4.7). Having suggested that a similar decision by a White, British woman influenced by accounts of natural birth might lead to the death of her child, the participant remarked that in these conditions, 'you couldn't say it wasn't her choice' (GP4.7). Thus, she appears to have held, White, middle-class women morally responsible for catastrophic outcomes where they had dismissed medical advice. Her criticism of this group appears to have been particularly trenchant as she perceived that the decisions of this group during labour were partially determined by their identification with essentialist notions of femininity that she believed were popularised in British accounts of natural birth.

Nonetheless, while participants described highly sceptical views of accounts produced by British proponents of natural childbirth, each of these participants considered that decisions made by educated, White women on the basis of such accounts were valid. In this way, a young White English obstetrician (OBS1), described two motivations for seeking to avoid a Caesarean section:

'... It's either from a cultural point of view or they want to do it naturally - to go through childbirth - they don't think they're a woman without it' (OBS1.4).

The participants thus represented, 'culture' as an opaque and indistinguishable set of behaviours that served to elide individual choice. In contrast, the participant appears to have immediately understood women's perceptions of labour pain as a means of establishing their feminine identity. Having indicated a similar perception of femininity and labour pain, a White, English GP (GP1), described how a, 'White, middle-class' woman chose to undergo a

caesarean section on a relative's recommendation. The participant rapidly appended her account by explaining that the woman had previously experienced a, 'horrible first delivery' (GP1.10). As such, she appears to have perceived that she needed to excuse her patient from cultural expectations that women should undergo undergoing natural birth. The participant not only appears to have engaged with these notions of femininity but appears to have perceived that these views were shared by the interviewer. Nonetheless, the clearest expression of health professionals' identification with the discourses of British proponents of natural childbirth, was offered by a young, South African obstetrician (OBS3). When prompted to consider that storytelling and accounts produced by the natural birth movement might represent equivalent forms of knowledge of labour and birth, this participant differentiated, 'cultural' sanctions against intervention among African women from beliefs surrounding natural birth among, 'rich, White' women (OBS3.5). She maintained that in the case of the latter group:

'... No, no, no, no, for them it's to do with choice... it's your body, you choose. The feel they are strong enough to cope. It's separate from having a child. This is my body, this is my womb' (OBS3.5).

As such, the participant indicated that, 'rich, White' women whose labour choices were influenced by the natural childbirth movement, perceived labour pain as a means by which to signal their ownership of their bodies. Having collapsed the distinction between herself and the imagined speaker in describing how the woman claimed her ownership of her body and her womb, the participant appears to have shared this view. Similarly, in a later account (OBS3.10), the same participant described how women who were influenced by the natural childbirth movement chose to forgo pain relief as they sought to protect their bodily, 'integrity' (OBS3.10). The participant also suggested that this group viewed obstetric intervention in terms of, 'having their body violated' (OBS3.10). She continued to contrast the willed agency of women in this groups with their inevitable experience of transgression during birth:

'... For a woman like this [rich, White], when she loses control – when she's screaming and shouting... she feels like an animal. And as a first-world women, I know how she feels.... Because you control your body through contraception, you control your fertility through abortion or not to abort, you control you finances. You know, you own property...' (OBS3.10).

Having suggested that these practices represented a means of establishing individual agency over the body, the participant returned to consider the experience of birth and demanded, 'why can't you control your body?' (OBS3.10). Conversely, she explained that:

'... your African or illiterate woman doesn't feel it when she loses control, because for her it's fine and normal' (OBS3.10).

The participant thus perceived that the experience of labour pain served to reduce, 'White, rich' women to a bestial status. Nonetheless, she represented the potential loss of human status in pain as being readily accepted by less-educated, Black women. This suggestion of the potentially animal status of *subaltern* women thus made by the participant recalls Iraqi participants' representations of storytelling among their poorer, less-educated compatriots (4.4.4). Similarly, by projecting non-subject positions onto these groups who were perceived to identify with the body, the participant appears to have defined her own femininity through practices of regulating her embodiment.

5.3 Defensive narrative strategies to contain difference

This section will describe participants' uses of categories of class, education and agency to contain the difference represented by, 'non-White' women within the information giving encounter. In the first sub-section (5.3.1), the deployment of these categories will be considered as these functioned to cast doubt on practices of promoting informed choice among women from Black and minority ethnic groups. The second sub-section (5.3.2), will trace how notions of class and education were represented in the accounts of migrant health professionals from Southern Europe, Africa and India.

5.3.1 'Control', Education and the 'West'

A relationship between notions of, 'control,' class, and education, and 'Western' culture was configured separately - but in complement - to that of willed agency, maternal responsibility and the appropriate use of information that was outlined above (5.2.1). The means by which this relationship informed participants' practices of information-giving was illustrated through the account of a young, Spanish GP (GP3, see 5.2.2). Having explained how poorer, less-educated Arab men prevented their wives from becoming his patients, he continued to explain that Arab Muslims who used his practice might be divided into two types. He recounted that these types were easily told apart, since the private patients who comprised one group were:

'... very smart, very tailored and elegant. Of course they speak good English too' (GP3.2).

In contrast, the participant explained:

'... you have the very traditional ones... They come from places... like you say from Yemen or Morocco. Their English is bad. Really only the men speak, the women just sit there...They have followed them here [to London] and they follow them into the practice but they carry on like they've never left ' (GP3.2).

By associating the inability to speak English with, 'tradition' and with women's reticence within the medical encounter, the participant thus opposed tradition to feminine agency. He continued to explain that women belonging to these, 'traditional' groups had followed their husbands into migration and continued to follow them directly into the medical encounter. By suggesting that these less-educated, Arab women sought to reproduce atavistic gender behaviour within the medical encounter, the participant appears to have indicated that the cultural difference of these groups served to compromise the basis of the medical encounter in the (British) public sphere (5.2.2; 5.2.3). The participant continued to contrast Arab, 'tradition' to his perception of the individual status of women in 'Western' family life by explaining:

'... I think in the West, there is an idea of the individual... For Arab families, I don't think that's true' (GP3.2).

Having thus associated Arab, 'tradition' with the radical reduction of the status of the individual, the participant recalled how a non-English speaking Yemeni woman gazed at him, 'like a beast' where she failed to understand his interpreted questions. Accordingly, he appears to have suggested that through failing to learn English, less-educated Arab women were further delegated to the status of non-subjects.

The participant continued to the educated status of Arab elite women. Accordingly, in the following account, he praised, 'educated' Saudi women:

'... they're exactly like [pause], international... They're educated and when you get education they are the same as any other patients. They're interested in best practice. Like any other mother, they put the baby first' (GP3.3).

The participant thus appears to have sought to justify his perceptions of the inferior cultural difference of Arab, 'tradition' by suggesting that education enabled elite Arab women to adopt, 'international' identifications that were also no different to those of British women. Accordingly, by casting off their cultural difference, the participant described how women in these groups were thus able to make decisions on their maternity care. Hence, he recounted how 'educated... Saudi,' women sought to:

'... weigh up all the risks and benefits from what you tell them. For example the Saudi women are very interested in where they should go to have the baby, what kinds of options, the birth pool...' (GP3.3).

The participant's reference to women's choices of the location of birth and the procedures to be undertaken during labour imply that he understood the, 'international' or, 'Western' orientation of this group in terms of their practices of consumer choice within the maternity care system. Given that these were private patients, his emphasis on their choices may also reflect that health professionals tend to place a more pronounced emphasis on women's individual agency where they pay directly for their care.

An older, Indian obstetrician (OBS5), similarly represented the limited agency of less-educated women from Black and minority ethnic groups. The participant related the preferences of women from these groups for vaginal delivery to their, 'cultural beliefs'. However, having continued to consider women from these groups, she predicted that, 'as women become more informed' they might chose elective caesarean deliveries (OBS5.4). She associated assisted delivery with, 'having a lot of control in your life'. Hence she continued to explain:

'I think in the Western world it's very different, a lot of women are managing things on their own rather than having a lot of extended support and they need to be able to very precisely plan out everything if they've got other children and they've got... work and whatever' (OBS5.4).

Accordingly, the participant related the, 'control' over the body that she understood to be offered by caesarean deliveries to women's commitments within a, 'Western' model of social organisation. In the following story, the same participant (OBS5), described how prenatal testing was intended to serve to reassure pregnant women. She identified a group of older women who, 'are actively seeking' information and who, 'don't mind going to private places' (OBS5.3). Having contrasted the behaviour of this group who may chose private care, group to that of women who did not have, 'much English...' she described the latter group as being, 'very difficult to convince' to undertake pre-natal testing (OBS5.3). She also viewed this group as not being, 'very interested in the results' (OBS5.3). In contrast, she represented private patients as being, 'more informed generally about things' and as being, 'more aware of themselves' (OBS5.3). In this way, she appears to have viewed class and education to determine women's *proper* use of information. However, she also appears to have perceived that women's identifications with the, 'West' enabled them to develop a more evolved sense of self.

A young, South African migrant obstetrician also contrasted the liberating effects of education with the traditional identifications of Arab groups in Britain. Thus, having suggested that the, 'cultural' identifications of Arab migrant women led them to develop a fatalistic attitude, she imagined a clash of perceptions between migrant and second-generation Arab women in Britain:

'... They're going to go to a school where the ethos is going to be 'you must be a strong, independent woman, have a career, be yourself'... Where this whole individual ethos exists and then they go home, to their mother and it's not an individual ethos, it's a community ethos so how do these girls then equate the two?' (OBS3.7).

Having perceived that the British education system served to teach women to act as independent agents, the participant represented British schooling as enabling second-generation women to assume their subject status in the sphere of work. Nonetheless, she viewed second-generation women as being hindered in taking up the status of individual agents by their mothers' cultural influence. The participant continued to recount how the Arab mothers from the migrant generation sought to hinder their daughters from making the transition from the domestic and cultural sphere to the British public sphere of education or health services. Thus, the participant described how migrant Arab women:

'... brought those third-world values with them. But their children who are born are going to a first-world school. They're not going to have a language problem about accessing health care. They're going to have different demands from their mother. And how does their mother, having them now, guide them through this process - when she's not in control?(OBS3.7).

The participant thus viewed Arab cultural identifications to directly oppose constructions of the self-responsible agent that she understood to be taught in British schools and to be demanded in the British public sphere. The participant concluded:

'Once you have women who've not been educated in this country, you have a cultural problem' (OBS3.7).

The problem perceived by the participant would appear to be that of cultural difference itself. As she appears to have understood that Arab, 'cultural' identifications to be alien to the British public sphere, the participant appears to have suggested that cultural difference represented by less-educated, migrant women placed an unjustifiable strain on the provision of NHS maternity services (5.2.2; 5.2.3).

5.3.2 Education as a containing category for ethnic difference

Participants who belonged to Black and minority ethnic migrant groups, used the categories of class and education to contain perceptions of cultural differences with which they might have been identified. Hence, an older Jamaican midwife (MD2) associated her practice of feeding her own children on demand with the maternal practices, 'career women... secretaries, teachers and midwives' (MD2.9). Having mocked a family peculiarity of waking children at fixed times, she thus presented her approaches to mothering in a culturally indeterminate familial and professional context. Similarly, an older, Indian obstetrician (OBS5), described how, 'from a cultural point of view' she had suffered anxieties over her choice to delay starting a family (OBS5.6). Nonetheless, she dismissed the saliency of such identifications, 'as a doctor' (OBS5.6).

5.4 Visual metaphors and institutional spaces

This section considers participants references to biomedical knowledge through their uses of metaphors of visual images. It reviews their figurative uses of the hospital space to configure their own identifications and to construct their expectations of patient behaviour. In the first sub-section (5.4.1), participants' uses of visual metaphors to describe their practices of information-giving are traced. The second sub-section (5.4.2), explores participants' uses of the hospital space to delimit cultural difference. The final section (5.4.3), considers participants' presentation of the spaces in and around the maternal body as these served to indicate their professional and gender identifications.

5.4.1 Visual metaphors for narrating knowledge and consciousness

Participants use of visual metaphors to describe practices of information-giving appeared to rest on their assumption that knowledge of participants' bodies was fully available to them. Participants also appear to have assumed that they acted directly on patients' consciousness through information-giving. In this way, a younger, Indian, male midwife (MD4), described a model of the patient's mind in which expectations can be, 'put at a certain level' through his provision of information (OBS4.3). An older, English GP (GP2) also perceived that health professionals were able to act directly on patients' minds through providing information. Accordingly, in considering attitudes to abortion, she explained that:

'... your women are the most closed off. You really need to get information up to a certain level in those categories. Then things begin to change' (GP2.1).

The participant thus referenced the understanding of the inaccessibility of the bodies of Muslim women who were, 'closed off', to medical intervention that has been discussed above (5.2.1). However the participant also suggested that the minds of Arab Muslim patients were vessels that she might fill with information (GP2.1). A younger, White, English GP (GP1), drew on a similar model of information-giving as a means by which to manipulate patients' consciousness. She described the range of women's states of awareness of pregnancy and motherhood in terms of textual referents. Accordingly, she recounted how some women brought lists of questions, while for others, 'it's like a blank page' (GP1.5). She described how providing information to the latter group served to, 'switch... on another light in the house' (GP1.5). In this way, she appears to have imagined her provision of maternity information to patients to enlighten them in a particularly direct way.

Where the form of information was modified for communication with patients, participants indicated that such changes related solely to relating information on hazards to the pregnancy to the patient's physiology (4.3.1; 4.5.2). Accordingly, an older White, English obstetrician (OBS2), described how information on a breach presentation that was given in the woman's, 'own sphere' would reflect projections of risks in her particular case (OBS2.2). She then indicated that the patient's response to this information would determine, 'how you tailor it from there' (OBS2.2). A younger Irish, male obstetrician (OBS4), deployed the same metaphor to describe how he prepared information for particular patients. Having described how, during the first consultation with a patient, he would provide a, 'blanket speech' on women's normal progress through pregnancy, he explained that:

'... once you can judge the level of intelligence the woman operates at, you can tailor it to her personally' (OBS4.1).

As the participant whose account is discussed above (OBS2.2), perceived that the patient's consciousness was visually available to her, so the second participant used the same image of tailoring to suggest that the patient's consciousness was apprehensible in the same way as the patients' body presented itself to his measuring regard. A young White, English GP (GP1), similarly suggested that she communicated directly with the patient's mind rather than their embodied selves. The participant perceived that health professionals' practices of information-giving tended to focus on women's choices of the location of the birth at the expense of more general questions entailed by entering motherhood. She continued to explain that information given on women's embodied changes during pregnancy, 'opens out new vistas' to them (GP1.4). Such prospects on women's embodiment that the participant viewed as being provided by maternity information appear to have rested on the notion that the body

was discovered by patients' active consciousness. Through providing the patient with a perspective from which to survey her body, the participant described how she and the patient would plan, 'ways to go from there' (GP1.4). She also recounted how she and the patient would use this information to decide, 'which route to take' were conditions to change (GP1.4). The participant thus imagined the patient to project herself forward into future events and to engage with the participant in controlling unexpected embodied events from the perspective offered by medical knowledge.

5.4.2 The hospital space used to narrate difference and identification

Participants' representations of the hospital space served to construct their professional belonging and to contain their perceptions of cultural difference. Participants used spatial metaphors of the hospital, to suggest that the presence of women from Black and minority ethnic groups as users of health services served to disrupt their provision of maternity care. Women from Black and minority ethnic groups were thus represented as 'cultures' and were perceived to occupy space in the hospital. Accordingly, a younger, South African migrant obstetrician (OBS3), represented the cultural difference of Arab Muslim women through their movement within the hospital. In recounting the behaviour of Arab Muslim women around gender preferences for health professionals, she thus described how:

'... they sit around in clinics and they - they sit in the clinics.. Here in this hospital, they sit in the clinic and they watch' (OBS3.12).

The participant appears to have signalled the determined physical passivity of the group through repeating the word, 'sit'. Having referred to her position and that of the interviewer, 'here' in the hospital, the participant positioned the listener inside the institutional space in which the Arab Muslim women were said to, 'watch' which doctors, 'come in' (OBS3.12). Having thus positioned herself and the listener inside the hospital, the participant recounted how, when a woman doctor entered the clinic, the women would, 'immediately all rush forward to the reception box' (OBS3.12). The participant described how these women unanimously and simultaneously demanded to see the female doctor. Conversely, she then recounted how, at the approach of male obstetricians, Arab Muslim women, 'all run to one corner of the corridor' (OBS3.12). Having thus represented Arab Muslim women as a tide that swept forward to access the female doctor, the participant further described this group as a, 'clump'. She recounted that this mass of women acted in a manner that was threatening to less senior staff:

'It's very, very strange. But I've never [before] seen a clump of women just actively grabbing the receptionist and... almost accusingly telling her... 'we know you've got a female doctor here. It's funny, if they see X, or X, who are my senior colleagues and could help them a lot more, all run to one corner of the corridor, to get away from their doors ' (OBS3.12).

Through acting uniformly and through their bodily density, the participant suggested that this mass of women blocked pathways through the hospital. Accordingly, the 'cultural' difference that was represented by this group again appears to have been suggested through depictions of the density and opacity of the bodies of individual Arab Muslim women (5.2.1; 5.2.2; 5.4.1). The disruption the participant thus described as the bodies of Arab Muslim women acted as a tidal force, appears to have been analogous to the disruption suggested where women in these groups demanded to see a female doctor.

Having continued to describe how she had previously sought to see Arab Muslim patients, the participant remarked that:

'It's not on. It's not fair that I take the burden of the work. They have to get used to it' (OBS3.12).

Accordingly, through depicting the incursion of the bodies of Arab Muslim women into the hospital space, in which she and the listener were positioned, the participant appears to have sought to justify her decision to resist the disproportionate claims made by Arab Muslim women on her time. Nonetheless, by suggesting that the presence of these groups serve to disable the service, she may also have indicated a broader conception of the ill-founded basis of extending notions of appropriate care to Black and minority ethnic groups (5.2.1; 5.2.2; 5.2.3; 5.3.1).

An older English obstetrician (OBS2), similarly suggested that Muslim patients failed to adopt the responsibilities entailed in using NHS services. Having described how she had advised a Somali woman to undergo a Caesarean section, she recounted how the woman avoided following her advice by:

'... absconding from her midwife, her GP, everywhere' (OBS2.3).

The participant thus indicated that the woman had crossed the boundary from maternity services organisation. She continued to describe how the woman, 'came...back' into the service. Having refused further intervention, the participant explained that the woman had 'gone back into the community' (OBS2.3). The participant thus appears to have suggested the dense and impenetrable nature of the Somali community. She also drew on references to the

opacity of the bodies of Muslim women by recounting that the woman was protected from the view of health professionals by being :

'... surrounded by all these other women who've had awful deliveries. Who've not through them in circumstances that are not as dire' (OBS2.3).

As such, the participant opposed the public sphere of NHS services to the private or cultural sphere of the, 'community'. Having drawn on constructions of the density of the bodies of Muslim women to emphasise the cultural difference of these groups, the participant also appears to have suggested the demerit of Muslim groups to receive equitable care in the British public sphere. Hence, where the participant predicted that the woman would, 'come knocking at our door' at the onset of labour, she described how the woman's actions would create a, 'difficult' situation for the participant and her colleagues (OBS2.3).

As has been discussed above, participants perceived that biomedical information served to offer patients a perspective from which to plan their progression through pregnancy (5.4.1). Similarly, obstetrician participants conceived of the hospital as a space that was organised from the perspective offered by their expertise. Accordingly, having been prompted to consider the functions of information-giving during the early stages of a difficult labour, an older obstetrician participant (OBS2), recounted that:

'... My role is to look in to things... to see how it's going and to reassure the woman or the midwife that things are not as bad as they seem. So two realms really' (OBS2.1).

Having mirrored participants' uses of visual metaphors to describe the functions of information-giving, the participant's use of this metaphor of envisioning the woman's state appears to have represented the woman's embodiment as a space that was governed by her organising eye. Similarly, in conditions where birth did not progress normally, the participant described how:

'... I'm there to put things back on track... for the good of the mother' (OBS2.1).

Having been able to guide the events of birth along the, 'track' set out by her experience and her biomedical knowledge, the participant would appear to have figuratively positioned herself above the events. Similarly, in describing a delivery where the birth canal was blocked, the same participant recounted how:

'... when she's there in labour and there's something that's not opening, that's my field. I get things going' (OBS2.1).

The participant's reference to the woman's position, 'there' thus appears to have referred interchangeably to her own medical knowledge of the woman's progression through labour and to the woman's location in the ward. The fluidity the participant introduced between the two concepts appears to have enabled her to claim both the event and the patient's body as her, 'field' of operation.

5.4.3 Narrating spaces in and around the maternal body

Female obstetrician participants presented ambiguous representations of the internal spaces of women's labouring bodies and their relation to external spaces. They appear to have used these accounts to describe the highly modulated positions they had adopted on the relation of feminine agency and the perceived cultural identifications of 'non-White' women.

In the course of consecutive stories (OBS1.11; OBS1.12), a younger, English obstetrician (OBS1), formulated a view on feminine agency and cultural norms that appears to have destabilised the representative system through which the category of, 'non-White' women was produced. In the first account, the participant described the functions of maternity storytelling among Somali women (OBS3.11). Having considered Somali women's reluctance of accept advice to undergo intervention, she explained that cultural censures on intervention operated, 'regardless' of the effects on the health of the baby, 'coming out' of the mother (OBS3.11). Having described the mother only in terms of the function of her uterus/vagina, the participant appears to have sought to erase the mother's individual agency in the process of birth. In the following account, the participant initially appears to have expanded on her reflection that women might seek to follow cultural precepts in the face of medical opposition. Having described the death of a baby whose Somali mother refused to give consent for the participant to perform a Caesarean section, the account focused on the visual image of the foetal heartbeat that was displayed as a pulse on a monitor (OBS1.12). Having explained how the baby's progress was blocked by the woman's infibulation scars, the participant recalled her side of a dialogue with the mother and described how she had advised her:

'You're not fully dilated, I can't get it out any other way' (OBS1.12).

The foetus's trapped condition was thus imagined as having been interior to the woman's embodied self. Nonetheless, as the mother refused appeals for the baby's safety, the participant recalled how:

'... I sat and watched the trace, go down and down and down...' (OBS1.12).

The participant thus suggested that the trace of the foetal heartbeat, that represented its life, was externalised through the woman's refusal to undergo a Caesarean section. Accordingly, while the opacity and inaccessibility Muslim women's bodies was elsewhere associated with the cultural difference of Muslim cultures (5.2.1; 5.2.2; 5.4.1; 5.4.2), the participant implied that the density of this Somali woman's body resulted from her individual choice. The participant thus represented the Somali woman's decision to follow cultural precedent as having served to enact agency on her body and to exteriorise her foetus. The effects on the foetus that the participant perceived as having followed the mother's willed action, appear to be similar to an account provided by a Moroccan participant (4.5.1), where the participant understood that a scanned image had served symbolically to externalise the foetus. In contrast to that account however, here the agency of the mother herself was shown to directly cause the life of the foetus to be reduced to the visual image of its heartbeat. Having returned to consider the electrical pulse of the foetal heartbeat, the participant described her own passive state, 'sitting' through the time it took to reduce to nothing. Through depicting herself as having been physically immobilised and unable to act while she watched the screen of the monitor, the participant suggested that her own willed - but also embodied – agency in the event had been disabled by the mother's decision. Accordingly notions of, 'culture' as serving to negate feminine agency that appear to have underlain participants' positions on information-giving (5.2.1), were collapsed by this participant appear where she sought to establish the individual responsibility of the mother for her actions.

Another White, English female obstetrician (OBS2), used a similar narrative strategy of exteriorising feminine agency to divergent ends. As such, in describing procedures undertaken to open the vulvae of infibulated Somali women, the participant noted that infibulation:

'... is usually not done very well. They just fuse the labia. So really all you need to do is to slice upwards and make a decent opening' (OBS2.8).

Having thus related the violent action of, 'slicing' to her professional function ('to make a decent opening'), the participant appears to have inculpated her professional practice in an act

of violent incursion analogous to that of infibulation. Having continued to describe the practice of infibulation, the participant reflected that:

'The idea is to slice the clitoris. It's seldom done properly, thank God, because if it's done really well, then the little girl could bleed to death. I read of a case of that recently (OBS2.8).

The participant thus transposed criteria of clinical performance onto the act of infibulation. Through the use of the notions of training and performance ('properly', 'done well'), and the use of the term, 'slice' she further associated her professional actions with the radical form of harm entailed by infibulation. As women are generally anaesthetised during obstetric procedures of cutting, the participant would appear to refer to a symbolic value of violence entailed in the act of opening the maternal body. Having thus described how notions of symbolic incursion underlay her interventions on Somali women, the participant thus appears to have equated her embodiment with that of Somali women. She thus located their shared feminine embodiment within a web of cultural meanings within which obstetric intervention emerged as necessary but also harmful to the woman and to herself.

In direct contrast to the suggestions of shared feminine embodiment suggested above, the first participant (OBS1), sought to deny the symbolic meanings of feminine embodiment. Having suggested that Somali women sought to avoid communicating with her, the participant was asked whether women in this group might perceive her presence in the delivery room to represent a pressure on them to consent to interventions. In responding to this question, the participant laughed and explained:

'... that's it. You become like the ripper. I think they see a shadow of me with a knife like that' [makes cutting motion as in the film, 'Psycho'] (OBS1.16).

Having referred to two, male, sexually-motivated, killers of women in the popular imagination of British youth (Norman Bates, the killer in 'Psycho' and Jack the ripper), the participant invited the interviewer to laugh at fears of intervention among Somali women. This strategy successfully minimised the potential of symbolic violence entailed by her acts of obstetric intervention. Nonetheless, the participant appeared to be less than convinced by her appeal to the cultural reference through which these associations were diffused. Accordingly, by privileging popular British discourses over feminine embodiment, she may have exacerbated wider existing tensions between feminine identity and professional belonging The account discussed above, appears to suggest that female obstetricians may only partially resolve these tensions.

5.5 Narrative and patients' orientation to motherhood

A further group of health professional participants expressed views of the functions of information that diverged from the models discussed above (5.2). This section explores these modified views and also raises questions concerning the universality of participants' uses of the model of 'non-White' women. In the first sub-section (5.5.1), participants' critical views of the uses of maternity information to control expectations and to regulate the female reproductive body are described. Conversely, in the second sub-section participants' perceptions of the functions of information-giving in offering social recognition to women's transition to motherhood are considered (5.5.2). Within the final sub-section (5.5.3), participants' practices of providing personal accounts of maternal embodiment are discussed as these suggest emerging views of feminine agency.

5.5.1 A critique of using information to manage expectations of motherhood

Participants described how the use of maternity information in decision-making served normative cultural functions among White, English patients. An older White, English obstetrician (OBS2), thus recounted that women who used information produced by the natural birth movement sought to manage their own labours through regulating their embodiment:

'... if you do this, you won't do that and you haven't done enough aromatherapy things to turn the baby, or to move the baby or you're not active enough' (OBS2.9).

The participant explained that, by providing information in the form of paired obligations, such information served to fuel unrealistic expectations of control were among 'educated, White' women. Given the construction of such information, the participant concluded that these women were, 'set up for failure' during birth (OBS2.9).

Similarly, an older White, English GP (GP4), explained that, 'younger, White, English' women from nuclear families did not generally see pregnant and birthing women before they were themselves pregnant. In the absence of first-hand knowledge of the embodiment of pregnancy and birth, she perceived that these women sought medical information to orientate them to pregnancy:

'... because, 'it's the body'... it's seen as being something medical, which is only one small aspect of it' (GP4.4).

Consequently, she perceived that women's perceptions of 'the big change,' represented by entering motherhood were limited to the knowledge of the physical processes of pregnancy and birth that they obtained from maternity information. Given the participant's view of the holistic nature of pregnancy and birth, she might have been expected to privilege embodied knowledge over the use of information to survey maternal embodiment. Nonetheless, in a previous story, she described the functions of providing information on hazards to pregnancy in the following terms:

'I suppose you could say that they begin to act like mothers yes. Most women already know what they should do in terms of healthy eating, but they do expect you to tell them' (GP4.3).

Accordingly, the participant perceived that women's use of information serves to regulate their embodiment. She perceived that such practices of regulation served to instigate women essential maternal practices. Similarly, a young second-generation, Jamaican midwife criticised desires among a mostly, 'English', group to, 'pass...tests that we give them' (MD1.3). Nonetheless, the participant continued to recount how she took the opportunity of providing these women with test results in order to reprove those who had not, 'booked classes' (MD1.3).

A more developed perspective of the cultural uses of maternity information to orientate to birth, was offered by participants who focused of its deployment to support British gender norms. An example of this view was offered by a young Irish, migrant midwife (MD3). This participant described how, 'White women who are a not that old' recognised their pregnancy as a, 'process' over which they had limited control (MD3.6). She described how this group attended antenatal classes and aimed for unassisted deliveries. She further explained that women within this group did not perceive unassisted labour as 'a religion' (MD3.6). Nonetheless, following the birth, the participant explained that these women's perceptions of the event tended to change. As such, she recounted how:

'... doing the postnatal visits can be embarrassing almost because they think that somehow it was me being there and talking them through it that made it work out fine' (MD3.6).

Having perceived such interpretations of her professional role to have derived from women's desire to construct certain kinds of maternal identities, the participant recalled having been invited to a, 'modern christening' by a woman whose child she had delivered. The participant described how she found herself introduced to the woman's friends in a way that she perceived as having been inappropriate:

'... all her friends were there and she kept introducing me to people like I knew her really well - like the birth was something to do with me as a person. Yeah, they thought it was a spiritual thing. And I'm not saying anything about that, but I didn't know this couple well at all. It was professional... I thought they must have told all their friends I was some kind of white witch (both laugh). I wish I'd have dressed up! (MD3.6).

The participant thus perceived that both parents had projected spurious cultural meanings onto her communication with the mother during labour and birth. She appears to have resented the role thus projected on her, that she may have perceived to derive from English conceptions of Irish cultural difference. Accordingly, she mocked the quasi-mystical notions of femininity that she perceived to have underlain the maternal identity that both parents had sought to construct.

A young, male, Irish obstetrician (OBS4), also criticised the uses of maternity information among White, middle-class couples. Hence, in comparing the behaviour of a number of groups, he described how:

'... highly-educated, White fathers, are the worst. They ask too many questions... They don't want to know that it's not them who's going to push the baby out... and their wives, think this is OK. This is what a man does... They see it on TV, in soaps or whatever, these couples you know, deciding together' (OBS3.4).

The participant thus perceived depictions of birth, in British television series to de-emphasise the physical nature of birth. Accordingly, he represented notions of shared decision making as having served to encourage women to abdicate their embodied agency in favour of their male partner's will. He continued to explain how these cultural and gender norms influenced the use of information:

'... if you ask a woman in labour, 'we need to do this now, what do you think?' And they won't even answer. They'll turn around and say, 'what do you think darling? They have their own careers – their own lives but they have this idea that men have to be forthright and involved... in physical decision making – whereas it's actually their bodies' (OBS4.6).

Having thus appealed to the embodiment of the child in the woman, the participant would appear to have sought to argue against the abstraction of birth as an act of will. Nonetheless, having imagined advising a woman how he and she they would need to manipulate her embodiment ('we need to do this now'), he appears to have recognised the function of shared

decision-making in imposing the agency of the health professional and the patient on the patient's body. The participant continued to refer to women's economic independence as a condition that should protect them being conditioned into transferring their transfer of agency over their bodies to men. However, by disembodying feminine agency, the participant perceived that models of shared decision making served to diminish women's ownership of the experience of birth. Accordingly, while he perceived women's control of their work was seen to have been empowering, he also described how the use of maternity information to excise control over the feminine reproductive body served to consolidate men's authority within White, educated couples. He thus indicated how the lived reality of gender relations may serve to disable the constructions of feminine willed agency on which models of shared decision-making were based (5.2.2).

5.5.2 The information-giving encounter and interpersonal recognition

Midwife participants appear to have perceived that the information-giving encounter offered an opportunity to provide social recognition for the mother's changing embodied state. A younger, second-generation, Jamaican midwife participant (MD1), contrasted the midwife's relationship with the woman with the more formal relationship of the woman with her GP. She described how, during consultations with her, women might introduce difficult issues using the formula, 'I know this may sound silly but...'(MD1.4). The participant continued to provide the example of women's needs to obtain advice on their problems of stress incontinence. Within these situations, she explained how she used social gestures to introduce the subject and to ameliorate women's experiences of shame or embarrassment. In concluding her account, she reflected that:

'... if they can't trust you with a thing like that, what will they do during labour?' (MD1.4).

She thus suggested that the woman's trust in the midwife during birth rested on the social recognition that the midwife was able to extend to women during pregnancy. The participant viewed this process of recognition as having been reciprocal. Thus, within an earlier account, she described how her patients provided her with personal recognition through focusing on the overlap between her work and her private life. Thus she explained:

'... like I might miss an appointment because I've been up in the night, 'oh did you have a delivery?' and 'oh how did it go?' and, 'oh, how lovely'' (MD1.3).

Additionally, the participant indicated that through women's social interaction with the midwife they sought to access a community of pregnant women and new mothers. A young,

Irish, migrant midwife (MD3), similarly sought to extend a form of social recognition to pregnant women. Having explained how her young, Bangladeshi patients were isolated, she explained the value of recounting other women's experiences to them:

'[Stories are] more helpful because they are there. They [Bangladeshi women] can imagine how I went and talked to this woman and she said what I then tell them later. I think maybe it gives them a sense of company. There they are, having their baby but they're really kids themselves. They're ballooning out and changing. Yeah... they are really scared (MD3.2).

By recounting versions of her professional practice, the participant thus perceived that she held out a form of social recognition to her patients. She appears to have perceived that her accounts suggested to these women the possibility that they formed part of a community of other mothers. Through with suggestion of shared embodied experiences the participant perceived these isolated, young women were able to accept the embodied changes of pregnancy and to counter the fears that arose from entering motherhood.

5.5.3 The Information-giving encounter and paradigmatic storytelling

A practice consistent with narrating other women's maternity experiences was that of participants' acts of narrating their experience of their own pregnancies, labours and births. In this way, an older, White, English obstetrician (OBS2), described how she recounted the events of her own birth events to a woman whom she had advised to consent to an intervention. The participant explained that providing personal accounts served to:

'... give them something to work with so they can consider what they want to do (OBS2.13)

Having thus perceived that accounts served to exemplify the effects of various decisions during labour, the participant also explained that maternity stories should be told because they represented a, 'tremendous experience' that was, 'something that has changed your life completely' (OBS2.13). Hence, by providing personal maternity accounts during pregnancy, she appears to have suggested that she enabled women to place their experiences within a wider framework of meanings. The participant continued to describe the typical form of her personal maternity accounts. Accordingly, she explained how she would recount a series of, 'ghastly things' that led to the birth of a, 'beautiful baby' (OBS2.13). Having considered her first birth, she explained how she would recount:

'... a lovely story about how I didn't know my... my eldest one was very growth restricted and how we realised there was a problem and I had a crash section and HUP! he was alright' (OBS2.13).

Hence, in addition to offering a paradigm for decision-making, the first birth account appears to have served to enable women to recognise and understand their fears in approaching labour. Having continued to consider her second birth, the participant recounted:

'... I could tell you a lovely story about how I had a normal delivery after that. For me it's good that I had two forms of delivery so that I am all things to all people' (OBS2.13).

The participant thus indicated that her accounts serves as templates that women used to predict their experiences. Her notion of the need to match her account to predictions of the women's birth appears to have suggested that she intended her accounts to be used by women in making decisions on their care. Nonetheless, in considering her third birth, the participant remarked that:

'I had a breech for my third, which doesn't really have a story really because it was all planned in a way that was rather clinical actually but the other two... had a sense of excitement and make exiting stories' (OBS2.13).

She thus viewed her accounts as having been most effective when describing experiences of loss and uncertainty. She perceived these narratives as having functioned to contain women's fears of harm to their children through moving through the event of birth. In this respect, the participant's maternity narratives appear to have served similar functions to maternity accounts that projected through the dangers of birth that were shared among the Moroccan and Yemeni groups (4.3.3).

Having similarly suggested a sense of the dangers inherent in birth, an older English GP (GP2), nonetheless expressed a divergent view of the function of maternity accounts. The participant began her account by explaining that she avoided recounting her experience of her, 'dreadful, really dreadful delivery' (GP2.13). She continued to describe how her child was delivered, 'with turning forceps - which is now unheard of.' She then reflected that the birth had been, 'really unusual and frightening' (GP2.13). Immediately after delivering her child, she recounted how she was, 'really shocked and flat out'. Nonetheless, she was continually disturbed by colleagues who entered and left the delivery room. Having thus narrated the experience of giving her birth through depictions of disorientation, fear and vulnerability, the participant considered women's practices of recounting birth experiences in the following terms:

'... it sounds like cruelty really because half the time it frightens them even more' (GP2.13).

Having previously emphasised that the control of the body was fundamental to establishing feminine agency (5.2.2), the participant thus shared with Iraqi participants a perception of the danger posed women by accounts of the body in pain.

5.6 Conclusions

The chapter has discussed patterns in health professional participants' accounts of the appropriate uses of maternity information in the NHS. As has been suggested above (3.4.5), a series of latent oppositions emerging from these accounts, was derived from a central opposition of feminine embodiment and its, 'control' through the use of information in decision-making. This section will use a modified structuralist approach to explore the means by which each set of oppositions produced perceptions of feminine embodiment and, 'control'. By exploring how each of these linked oppositions enabled health professionals participants to establish identification and difference, the cultural framework that structured the information-giving encounter will be more fully illustrated.

Personal agency and the status of the Arab Muslim maternal body

Having conceived that the *proper* use of maternity information entailed imposing willed agency on the body through acts of decision making, participants constructed a category of, 'non-White' culture that was defined through the absence of individual agency (5.2.1; 5.2.2). An important aspect of the construction of the essential difference represented by, 'non-White' women was the projection onto this group of identifications with the feminine body. Among African women, participants related these to valorising pain. However, they associated the embodied identifications of Arab Muslim women and Iranian women with bodily degeneration and shame (5.2.1; 5.2.2; 5.2.3; 5.2.4). Participants related perceptions of the opacity or density of the bodies of Arab Muslim, Somali and Iranian women, to the resistance of these Muslim groups to open their bodies to medical scrutiny through willingly consenting to examination or intervention (5.2.1; 5.2.2; 5.4.1; 5.4.2). Conceptions of the density of the bodies of this group were used to represent the incursion of cultural difference into maternity services. Thus, where Somali women were recounted to advise a peer to remain outside maternity services despite the dangerous nature of her pregnancy, they were seen to use their bodies to shield her from the view of health professionals (5.4.2). Similarly, where Arab Muslim women were recounted to demand to see female obstetricians, they were depicted as a threatening mass that invaded the hospital space and that disrupted its normal functions (5.4.2). Through depicting these groups as transgressing the boundaries of the

hospital and disrupting its functions, some participants appear to have made appeals to resist the perceived needs of Muslim women as users of the NHS.

Participants used notions of the lower educational and professional attainment of women from Black and minority ethnic groups to veil supremacist constructions of, 'Western' culture. Depictions of the *subaltern* nature of, 'non-White' groups also enabled health professionals from Black and minority ethnic groups to be included in the category of, 'White' culture (5.3.2). The fundamental function of education in health professionals' hierarchical constructions of, 'White' culture was suggested where African, 'illiterate' women and less-educated Arab Muslim women were associated with animal identifications in the accounts of health professionals who were themselves migrants (5.3.1). By suggesting the non-subject status of women who identified with, 'non-White' cultures, these participants appear to have drawn on the legacies of Enlightenment conceptions of the self-responsible subject in order to suggest that rights to equitable care did not extend to these groups (2.3.1; 2.3.2). Similarly, as the accounts of a wider group of health professional participants depicted, 'non-White' women as having been non-responsible, these participants also suggested that institutional and policy commitments to the equitable and culturally appropriate care of these groups were ill-founded (5.2.1; 5.2.2; 5.2.3; 5.3.1; 5.4.2).

Constructions of the non-subject status of 'non-White' women also served an intimate function in health professional participants' construction of their own gender identities. Thus, participants perceived that African and Muslim women's identifications with the female reproductive body led them to accept physical suffering and disabled them from acting as agents in making decisions on their care (5.2.2; 5.2.3). These patterns of representing, 'non-White' femininity thus appear to have been used by health professional participants of both sexes to assert that practices of bodily *discipline* represented the basis of feminine agency (5.2.3). Male and female health professional participants also associated notions of the inability of Arab Muslim women to demonstrate individual willed agency with their covered bodies. These depictions thus appear to have suggested the necessity of practices of uncovering the slim and sexualised body in order to establish feminine agency within 'Western' families and in the British public sphere (5.2.1; 5.2.2; 5.2.3).

As has been suggested to have been the case in the accounts provided by Iraqi, Yemeni and Moroccan participants, individual participants' negotiations of the opposition of feminine embodiment and, 'control' served to introduce contradictions into each of these terms. Accordingly, female obstetricians' representations of 'non-White' women through their identification with the feminine body led these participants to suggest tensions between their

professional identification and their embodied feminine experience. Where a Somali woman rejected a participant's advice to undergo an intervention, the participant blamed her for this decision that led to the death of her child (5.4.3). Thus, the construction of the passive agency of Somali women gave way to notions of guilt through which the individual Somali woman was punished for her choice to transgress the participant's notions of maternal behaviour. Another participant used depictions of the passivity of Somali women to infibulation, to suggest the violence of the removal of feminine agency that is entailed in obstetric interventions (5.4.3).

Storytelling and the proper use of maternity information

An element of, 'non-White' culture that was perceived to over-determine feminine agency was the practice of storytelling (5.2.3). These practices were associated with normative identifications with the body in pain, with familial systems of feminine oppression and with identifications with incontinence, bodily transgression and death (5.2.3). The racially selective basis of these constructions of maternity storytelling was suggested through participants' treatment of information produced by the natural birth movement, that were considered to support free choices of maternity care (5.2.4). A groups of health professional participants criticised the use of the maternity information to consolidate, 'British' cultural identifications with *disciplining* the feminine body. Nonetheless, in other accounts the same participants asserted that the appropriate use of maternity information in shared decision-making enabled patients to impose their willed agency on their bodies through the actions of health professionals (5.5.1).

Possibilities of destabilising the system of representation through which the categories, 'White'/'non-White' women were conceived were suggested through participants' individual negotiation of the opposition of storytelling and the *proper* uses of information. Hence, a participant described how she used her personal birth accounts to convey information to women to support their decision-making. In describing her accounts, she also suggested that she sought to provide a context within which women might attach social and cultural meanings to their progress to motherhood (5.5.2). By emphasising the relation of physical vulnerability to individual and social states of uncertainty, the birth accounts of this participant and another GP participant served to establish female embodied experience within a natural-cultural continuum (5.5.3). Nonetheless, having reflected the salience of the control of embodiment among health professional participants, the second participant also perceived the natural-cultural experience of birth to represent a, danger to feminine identity (5.5.3).

Notes to Chapter 5 :

[1] A similar perception of women's uses of maternity information to regulate their pregnant embodiment, was reflected in the narrative of a young, second-generation Jamaican midwife (MD1). This participant compared women's sudden focus on delivery in late pregnancy to the action of a, 'switch [that] goes on in their head' (MD1.8).

[2] The author to whom the participant referred is Sheila Kitzinger and 'the Kitzinger book' would appear to be, *Women's Experiences of Childbirth* (1978). Nonetheless, given the participant's strongly reasoned decision not to have children, she may also have referred to Kitzinger's essay, 'The Empty Womb' (1992, pp.141 - 193).

Chapter 6:

The maternity information-giving encounter as a cultural environment

6.1 Introduction

This chapter will review the study findings as these contribute new knowledge to each of the areas indicated by the research aims (1.7; 2.8). Accordingly, the construction of legitimate knowledge of the maternal body and its uses among Moroccan, Yemeni and Iraqi participants will be discussed in the second section (6.2). Patterns of constructing legitimate knowledge and its uses among these groups will be considered as they reflect patterns of constructing the symbolic maternal body serve to characterise the meanings attached to maternity knowledge among wider Arab Muslim migrant groups Within the third section (6.3), the construction and uses of maternity information among health professional participant groups will be discussed as these practices highlight structures of professional and personal identity. The following section (6.4) will characterise perceptions of the information-giving encounter among both main groups of study participants as these suggest shared strategies of producing identification and projecting difference. The fifth section (6.5), will discuss the means by which various Arab Muslim participants groups negotiated symbolic bodies within their maternity accounts and their narratives of birth in the London NHS. Within this section, participants' narration of experiences of natural-cultural 'openness', will be considered in relation to their adoption of new positions in Britain, within the community and in relation to the homeland and the Muslim diaspora. The section will close by relating these narrative strategies to the theoretical framework and to the concerns with feminine and post-colonial identities described in the introductory chapter. The study sought to produce cultural knowledge on both main participant groups in order to support the provision of appropriate care to Arab Muslim women in NHS maternity services. Recommendations to aid health

professionals accommodate cultural difference in maternity information-giving will thus be provided in the final section (6.6). Suggestions for policy development and further research will also be provided.

6.2 How do Arab Muslim women construct legitimate knowledge of the maternal body?

Participants across Moroccan, Yemeni and Iraqi participant groups considered pregnancy and birth to represent periods of cultural indeterminacy during which women needed to prepare themselves to take on a fixed cultural identity in entering motherhood (4.2.1). Accordingly, knowledge of the maternal body was legitimated to the extent that it reflected symbolic notions of the body (4.2.2; 4.2.4; 4.4.1). As legitimate knowledge of the body reflected the symbolic body that was constructed by participant groups, through using these forms of knowledge, participants were able to perceive of themselves as embodying relations of belonging to the homeland or to the diaspora (4.2.3; 4.6.2).

Within Moroccan and Yemeni groups, accounts of the experience of participants' mothers were used to imagine landscapes, localities and domestic and village spaces in the homeland. Through describing mothers' awareness of their pregnancies in performing their work and in emphasising their agency in minimally assisted births, these accounts enabled women to imagine temporal and geographic links to family origins through their own pregnant embodiment (4.2.2). Hence, a participant described how her mother accompanied the family livestock to look for new grazing land during her first pregnancy. As the rhythm of her walk calmed the foetus that she sensed as being increasingly heavy, so the participant's mother described how each day she would make out new markers of the boundary of the family's grazing territory in the Ta'ām region of Northern Yemen. Having described how her walking pace had calmed her own child, the participant recounted how as she walked around her home when she was pregnant, she would recreate her mother's journey. Accordingly, through her suggestion that her embodied awareness of the weight of the child served to connect her to her own mother's action, she appears to have imaginatively transposed the family's grazing territory onto her home in London. Similarly, a Moroccan participant whose family had migrated from the AntiAtlas mountains, described how her mother and grandmother would weave carpets together during her mother's first pregnancy. Having described the dark spaces of the house, the bright light in the courtyard and the noise of people passing in the street behind the garden wall, these accounts enabled the participants to feel 'part of that too' (4.2.2). Having continued to recount how through storytelling to other women she had, 'taken

her [mother's] place', the participant also appears to have placed herself in the village and domestic spaces of her mother's youth. A further Moroccan second-generation participant whose family had migrated from the Rif mountains, similarly imagined the family village through her mother's accounts of giving birth at night with no electric lighting. Having described how the midwife and the women of the family would block the windows with cushions to muffle her mother's screams during labour, the participant suggested the intimacy of the village in which the houses would be close enough for the noise to wake the neighbours. She further appears to have indicated the importance of norms around protecting other women from the fear of labour (see below). As the participant recounted how she had valued the accounts because she reflected it was her, 'time to hear the stories', they appear to have confirmed to her the fact of her immanent motherhood. As the stories were not imagined to change, they also appear to have formed a temporal and spatial link to a continuum of maternal experiences in rural Morocco.

Further accounts offered by participants' mothers were similarly organised around notions of a *resilient* symbolic body that was derived from notions of women's rural working practices. These were used strategically among the Moroccan group to create a common identity with other Southern Moroccan women migrants in London and were used within both the Moroccan and the Yemeni groups to anchor women's experiences in a web of relations to the homeland. Accordingly, they emphasised the salience of sensation – and labour pain – as a form of legitimate knowledge of birth. Through such accounts, migrant and second-generation women were able to place their embodied experiences within a framework of meanings derived from the homeland (4.2.3). The salience of storytelling and embodiment to the transition to a cultural identity fixed in a framework of meanings was suggested where participants recalled they had not been able to maintain embodied sensation during birth. Within these accounts, they described themselves as being unable to pass on their own stories and thus considered that they had not taken on an adult cultural and familial role (4.2.3). Since participants understood labour pain to offer legitimate knowledge of their passage to motherhood, participants who described accepting medical advice to undergo interventions constructed maternity information as a form of illegitimate knowledge. Participants thus suggested that interventions and examinations undertaken prior to these, had served to fundamentally disrupt their sense of embodied agency. The violence of the sense of uncoupling embodied sensation to a network of cultural meanings that was perceived to result from obstetric intervention was suggested by participants who recounted these experiences through metaphors of sexual humiliation. Similarly, where participants recalled they had accepted health professional advice to undergo interventions or to take pain relief, experiences of birth were narrated through images of incursion and passivity (4.5.2; 4.5.3;

6.4). Those who spoke limited English at the time of the birth recalled having adopted a radical form of passivity in their relations with health professionals. In one such case, a participant reported that her sense of passivity to the decisions of health professionals contributed to the death of her child (4.5.3).

A further component of the *resilient* body, was the perception of a double mind-body continuum that linked the emotional wellbeing of the woman to the physical safety of her embodied child (4.3.1). While labour pain represented a form of *legitimate* knowledge of entering motherhood, pain and the fear of pain were also perceived as being dangerous to pregnant women (4.3.1). Accordingly, fears of physical harm to the child conditioned the use of storytelling among participants where accounts were perceived to dwell on the disturbing possibilities of identification that might lie in the experience of pain (4.3.2). Similarly, experiences of having seen birth at first hand – or having envisaged birth through overhearing screams – were perceived as being disruptive to the relationship with the foetus (4.3.3; 4.5.3). Nonetheless, participants described how dangers represented by viewing visual images were contained through recounting narratives that moved through the event (4.3.3). Such perceptions of the dangers posed by seeing or envisaging birth may have related to the traditional interdiction on visual images in Islam and to powers associated with these in folk beliefs in some parts of the Arab world (2.4.1). Similarly, perceptions that recounting experiences of birth serve to restore relations of belonging to the resilient body would appear to suggest the continued cultural importance of the oral tradition among Yemeni and Moroccan groups (2.4.2).

The imperative to protect maternal equilibrium from the effects of physical and psychic 'openness' appears however to have related primarily to the use of maternity information given in 'the precautionary mode' (4.3.1; 4.3.4; 4.7). Medical information that was seen by participants to have invited them to survey their embodiment or to project into future events was perceived to endanger the safety of the embodied child (4.3.1). A participant criticised the practice of using maternity information to project into motherhood among wealthier, more evidently devout Muslim women, as being 'very English' (4.3.1). Another participant who described how she had used maternity information to imagine possible hazards to her child, recounted how her fear had passed to the foetus through her blood. Accordingly the use of information to survey maternal embodiment appears to have been seen to carry a form of infectious difference with which the participant suggested she had infected her child (4.3.1).

Similar associations with cultural incursion appear to have been made by Moroccan and Yemeni participants who described using visual images obtained from health professionals.

The degree to which uses of this illegitimate knowledge were considered to compromise the cultural meanings through which women understood their progress to motherhood was suggested where a Moroccan participant recalled how, having viewed visual images of her foetus, she perceived that it had been symbolically removed from her body (4.5.1).

While notions of embodied knowledge served to establish links with the *resilient* maternal body and the homeland, Yemeni and Moroccan participants nonetheless used maternity information to survey their embodiment and to project it through time (4.6.1). Where this was the case, participants continued to recount their actions as having been consistent with wider perceptions of maternal embodied agency. Participants' strategies of negotiating the *resilient* body from their positions as users of maternity information thus indicated a contradiction in the production of Arab Muslim femininities in London. As was suggested in the discussion of a study of the uses of consumer goods to establish a distinction between public and private space observed among Palestinian feminists in Haifa (Faier, 2003), these uses of maternity information along Yemeni and Moroccan participants suggest how participants sought to maintain their cultural difference by re-positioning the symbolic body in relation to their lived experience. By demonstrating how the symbolic body was strategically positioned to articulate women's difference in situations over which they had little authority, these findings confirm those of Sayigh, (1993) and Shabaan (1988) whose work on Palestinian women in Lebanon and Syria suggested a defensive use of militarised discourses of motherhood (1.7.2; 6.5).

While Moroccan and Yemeni participants imagined a symbolic body configured around embodied agency, Iraqi participants constructed a symbolic body around the control of embodiment. As this body enabled women to claim access to a public sphere of justice, rights and responsibilities, this was termed the *responsible* body (4.6.1; 2.3.1). Iraqi participants claimed access to the public sphere of the migrant community and of the Iraqi national community through practices of the spiritual and social instruction of their children (4.4.2). Participants suggested that these practices of instruction differentiated them from 'British' notions of motherhood and from those of the Iraqi rural, working-class (4.4.3). Having sought to define an essence of Iraqi motherhood, participants in this group thus imagined a symbolic body that reflected their nationalist identifications. Appearing to have reflected the construction of symbolic motherhood, Iraqi participants considered knowledge of the body to have been legitimate where it served to impose their individual control on their bodies. Accordingly, maternity information in its visual forms was used to imagine the effects of maternal behaviour on the foetus and to regulate such risks (4.6.1). This relationship with the embodied foetus was described in terms of the mother's adoption of, 'responsibilities' and in

terms of a realisation of the foetus' rights (4.6.2). In order to conceive of the foetus as having a distinct status to which rights could be attached, Iraqi participants sought scanned images of the foetus in which its embodied dependence on the mother was perceived to be obscured (4.6.2). Having been perceived as being revelatory of maternal cultural belonging, these images appear to have suggested a means for participants to project out of pregnant embodiment into practices of the instruction of children (4.6.2).

In contrast to perceptions of embodied knowledge shared among the Yemeni and Moroccan groups, Iraqi participants did not value pain as a means to signal cultural belonging. Accounts of experiences of pain were suggested to disrupt the cultural meanings through which embodiment was understood (4.4.4; 6.5). Accordingly, these accounts of the open body represented a source of cultural incursion into women's maternal identities that was similar to the effects of visual images and other medical information described by Yemeni and Moroccan participants. However, among the Iraqi group, the effects of compromising the meanings of maternal embodiment were perceived to derive specifically from storytelling that emphasised embodied agency and that was used to reconstruct homeland working-class and rural social contexts (4.4.4). Accordingly, participants in the Iraqi group constructed the symbolic maternal body and the legitimate knowledge of the body in ways that served to control the category of national belonging against the claims of rural and working-class compatriots that were imagined to have been configured around the *resilient* body.

6.3 How does the construction and approved uses of maternity information relate to the institutional and personal identities of NHS health professionals?

The construction of maternity information for decision-making within accounts produced by health professional participants also reflected participant's imaginative construction of a symbolic maternal body. Appearing to have drawn on similar notions of individual agency and the public sphere as those referenced in the construction of the *responsible* body among Iraqi participants, health professionals perceived that maternity information was used properly where it served to establish maternal agency through acts of decision-making. Thus, maternity information offered early in pregnancy was perceived to offer patients a perspective ('vista') on the body from which participants were able to point out, 'routes,' through future states of embodiment (5.4.1). Having been perceived from the perspective of maternity information,

pregnant embodiment was suggested to be organised and understood by patients through the 'routes' or 'ways' that had been projected through it by the health professional (5.4.1).

As participants appear to have conceived the *proper* uses of information as serving to produce the maternal body as the object of view, practices of *disciplining* the female reproductive body through exercise, diet and hairdressing a were perceived to display the agency necessary for acts of decision-making (5.2.1; 5.2.2). Patients' abilities to make decisions on their care were similarly perceived to rest on their perception of self-ownership, their choice of marriage partners and their 'cultural' identity (5.2.1; 5.2.2). The construction of the category of 'non-White' culture, in which all less-educated Black and minority ethnic women were contained will be discussed below as it related to defining the boundaries of the public sphere (6.4). Through this category of, 'non-White,' culture health professional participants suggested that where maternity information was not used by women to *discipline* their bodies, their personal agency was submerged in their embodiment. Accordingly, one participant suggested how 'first-world' women such as herself would feel themselves reduced to a bestial status through experiences of labour pain but described how such experiences of the loss of individuation in pain would be perceived as normal among, 'African...illiterate,' women (5.2.4). Through suggesting that less-educated, African women would consider bestial identifications with labour pain to be normal, the participant thus drew on a tradition of denying the humanity of these groups that has its roots in the European slave trade (Bush, 2000, see 1.3.2). Suggestions of *abject* status of non-White women were also made by participants who recounted how cultural pressures among, 'African' groups led individual women from these groups to seek to reproduce cultural norms of maternal suffering in birth (5.2.1). Similarly, where participants described accounts of pregnant and birthing embodiment that were passed on within 'Asian', 'Muslim' and non-English speaking families, these were suggested to lead women to identify with pain, death, and continual acts of birth (5.2.3). Through suggesting that identifications with embodiment entailed the loss of women's identity as subjects, participants were thus able to justify practices of *disciplining* the female reproductive body as representing the means by which individual feminine identities were established and preserved. Having defined women from Black and minority ethnic groups as a single category of non-subjects, the findings reflect suggestions made by Spivak that representations of third-world women that substitute their individual agency for notions of tradition serve to justify exploitative political and economic relations in the 'first-world' (Spivak, 1988, see 1.3.2). Similarly, by defining British femininities against representations of women from Black and minority ethnic groups, the findings offer a contemporary parallel to those of Burton (1992). Having described how Indian women were represented in British early twentieth century feminists discourses through notions of their non-responsible status, Burton traced the functions of these

representations in emphasising the cultural fitness of British women to participate in public life (1.3.2).

While health professional participants represented non-White women as a single group, Muslim women were systematically described through references to bodily density, inaccessibility or opacity. As Iranian women were suggested to resist practices of examination, less-educated Arab Muslim women were suggested to cover their bodies due to shame (5.2.1). Similarly, Arab Muslim women were described as being, 'closed- off' to suggestions of terminating their pregnancies and were perceived to block the interstices of the hospital in order to avoid being examined by a male obstetrician (5.4.1, 5.4.2). The bodies of Somali women who were imagined to encourage a patient to postpone a necessary obstetric intervention were imagined to shield her from view (5.4.2). The body of another Somali woman was perceived as having been rendered opaque and inaccessible through the woman's choice (5.4.2; 5.4.3). Accordingly, through participants' perceptions of the Muslim veiling and the avoidance of medical encounters with men, Muslim women represented the inverse of the symbolic construction of the body as the object of view. Participant's perceptions of fears of intervention among Somali women and their reactions to women's infibulated bodies, similarly appear to have confirmed their perception of the embodied – and hence non-controlling – vision of these groups. Where Muslim women were recounted to have rejected maternity information, their actions were thus associated with a desire to be 'left in the dark'. Similarly a participant described how a North African women sought to reproduce recounted experiences of birth in the family homeland in terms of the effects of this shortened temporal perspective on her ability to project forward into birth (5.2.1; 5.2.2). More broadly, Muslim women were suggested to fail to use maternity information to envisage their embodiment or to project forward into future embodied states (5.2.2). Given participants' perceptions of Muslim women's rejection of the exteriorised view of feminine embodiment offered by maternity information, *abject* identifications with disease, obesity and irrationality were projected onto Arab Muslim mothers (5.2.2). Similarly, an Arab Muslim woman who failed to use information to plan decisions later in pregnancy was recalled to have looked at the participant, 'like a beast' (5.3.1). Having implied the non-subject status of this non-English speaking Arab woman, the participant thus appears to have drawn on the representative strategies described by Fanon, through which bestial characteristics were projected onto colonised men in order to withdraw suggestions of common humanity from these groups ([1952], 1967, see 1.3.2). As representations of Muslim women appear to have drawn on systems of representing the inferior difference of all, 'non-White' groups, so they appear to have developed colonialist fantasies of veiling and seclusion in important ways (Apter, 1992; Lowe, 1991, see 1.6.4). Hence, while colonialist representations of Arab Muslim domestic life

were structured to invite the conquest and exploitation of Ottoman territory in North African and the Middle-East, the accounts of health professionals appear to point to a perception of the essential and inferior difference of Muslim societies that was suggested by Al-Azmeh (1993, see 1.6.2). The virulent nature of the repudiation of less-educated Muslim women through their associations with mental and physical decrepitude, appears to have derived from the political climate of the invasion of Afghanistan, the war and occupation of Iraq that framed popular British perceptions of the Muslim world during the period of the study. Accordingly, the study confirms and expands the work of Volpp (2003, see 1.6.2) on the undifferentiated uses of representations of Afghan women as symbols of gender inequality among American feminists. In common with the work of Burton, discussed above, the work of Volpp on the uses of Afghan women among American feminists prior to the invasion of Afghanistan proposed that American feminists negotiated greater latitudes of action through conceiving a role the feminist project in complement to military conquest. By constructing Muslim women as being culturally disabled from acting as individual agents, the representations of Muslim women reported in this study suggest that health professionals shared a similar perception that Muslim women might regain their feminine agency only through shedding their 'cultural' difference.

Representations of the under-developed individual agency of, 'non-White' women as a whole appear to have served to obscure tensions within the model of the disciplined feminine body where women were in labour. As maternity information was perceived to offer a perspective through which the woman and her health professional were able to survey her embodiment, so during more difficult labours, the woman's perspective was suggested to have been lost. Accordingly, where the body of a birthing woman was claimed by a participant as her, 'field,' and where a woman's embodied condition was imagined to be manipulated along the 'track' of a recognised trajectory through labour, the participant suggested that the woman was unable to share her view of the events of birth (5.4.2). The suggestion of the necessity of abdicating agency over the body in conditions of urgency thus appears to have represented an important limitation of the model of individual control of embodiment through maternity information. However, by ascribing the failures of maternity information to offer control over women's maternity experiences, to 'cultural' deficiencies, the promise of control thus appears to have been maintained for 'White' or 'educated' women.

6.4 How do both groups construct identification and difference in the information-giving encounter?

While the study has focused primarily on the information-giving encounter between the Arab Muslim participant groups and maternity health professionals, perceptions of the other actor in these encounters seldom emerged from participant's accounts. In contrast, among both participant groups, accounts of maternity information-giving served to project difference onto the other group involved in the encounter. Among Moroccan, Yemeni and Iraqi participants, perceptions of a cultural difference in the value of motherhood in Britain and in the NHS, served a crucial function in defining the boundaries of these minority groups. Participants' divergent constructions of the symbolic maternal body were reflected in their conceptions of the difference represented by health professionals. Iraqi participants perceived that their rights were not respected where GPs and obstetricians had not provided adequate choices for care. These perceptions of GPs and obstetricians, thus derived from participant's understanding of their relationship with these groups in terms of their rights within the public service and their claims to consumer choice (4.5.1). In contrast, a Yemeni participant maintained that a midwife was unable to support her during labour as she did not share her understanding of her embodied agency (4.5.1). The same participant contrasted the perceived recognition of the significance of birth among Yemeni midwives to the solely professional actions of their British peers. The views of the Yemeni participant in contrast appear to have served to imply notions of feminine co-operation and social recognition in the region of Khamir (North East of San'a) where she grew up. Within the first- and second-generation Moroccan group, a more individuated view of midwives emerged where a migrant participant described how a woman in labour was in need of interpersonal recognition from the midwife in order to maintain her sense of self in pain. Accordingly, NHS midwives appear to have been understood as being capable of offering such support. Nonetheless, having commented that in the wider context of maternity services there was, 'no sense that you've seen a life start that will...go on after', the environment of maternity services – rather than the actors in it – appears to have been seen as being responsible for the loss of wider social and spiritual views of birth (MFG4.8).

Among Moroccan and Yemeni participants, perceptions of the use of information in the, 'precautionary mode' and the acceptance of advice to undergo interventions and to take pain relief were recounted through images of transgression (4.5.3). Similarly, information-giving that led to intervention was perceived among a mostly Moroccan second-generation group as a form of coercion, through which health professionals imposed their control over the bodies

of pregnant and birthing women (4.5.2; 4.5.3). Iraqi participants did not appear to imagine the incursion of cultural difference through images of bodily incursion. Having sought scanned images of the foetus as a means of envisaging motherhood, participants in the Iraqi group recounted that opening the maternal body to medical scrutiny represented a means of identifying with the *responsible* maternal body (4.6.2).

As has been suggested above, health professional participants perceived that patients regulated the maternity care system by envisioning their embodiment through using maternity information. In contrast, less-educated Muslim women were represented as refusing to open their bodies to medical examination or intervention and were perceived to refuse to use maternity information to project out of their embodiment in time (6.3). Accordingly, the presence of Muslim patients in NHS maternity services that was perceived by health professional participants to have been disruptive to their personal identities (6.3), was also perceived to have served to compromise their provision of the service. Through representations of, 'Muslim,' identifications with maternal embodiment, health professional participants suggested that these groups brought private criteria to bear in the public space of the medical encounter. Hence, the refusal of Muslim men to have their wives examined by one participant was perceived to be inadmissible due to the participant's training, the location of the encounter in a professional space and due to the publicly-funded basis of the NHS (5.2.2; 5.3.1). Participants' perceptions that identifications with the body and the private sphere compromised the public basis of maternity services were represented through their use of images of the incursion of Muslim groups into the hospital (5.4.2; 6.3). Having represented the blockage caused by the uniform action of the dense bodies of this group, a participant thus recounted that the claims of Arab Muslim women to see a female obstetrician placed an unjustifiable strain on commitments to appropriate care (5.4.2). Parallels between the use of this schematisation of public and private spaces within these accounts and the exclusionary basis of the Social Contract, suggest the deep institutional roots of these personal strategies of withdrawal from commitments to appropriate care (Mills, 1997; Pateman, 1989, see 2.3.2).

Further conditions for the use of maternity services that health professional participants used to legitimate their discriminatory treatment of Arab Muslim were those of educational attainment and of social class (5.3.1). Poorer, less-educated Muslim women were thus perceived as being permanently excluded from the *proper* use of information due to their identifications with the feminine embodiment (5.2.2; 5.2.3; 6.3). Health professional participants who were themselves migrants appealed to representation of the low educational and professionals status of Black and minority ethnic groups as a means to assert their own professional belonging within the NHS. By emphasising how higher educational attainment

led to establishing British or 'international' norms of behaviour, these participants appear to have sought to distance suggestions of their own 'cultural' difference'. Having reflected a similar perceptions that education and professional status lead to the eradication of 'cultural' difference, wealthy, private patients from Persian Gulf states were perceived to have experienced similar needs for maternity information as those of 'British' patients (5.3.1; 6.3). Having suggested how patients' level of educational attainment and prosperity determined health professionals' perceptions of their needs for information and support, the findings echo those of Kirkham (1989, see 2.5.2). More widely, by demonstrating how health professionals ascribed to less-educated and poorer Arab Muslim women limited capacities to engage with information, these patterns endorse a study of the use of racist stereotypes of Black and Asian women among NHS midwives to determine their needs for care (Bowler, 1993, see 2.5.2).

While perceptions of interlocutors in the information-giving encounter related to broad constructions of cultural difference, exceptions to this pattern did emerge. Accordingly, a health professional's conception of, 'Muslim' women as being culturally unable to exercise individual agency broke down where she sought to blame a Somali woman whose refusal to undergo an intervention led to the death of her child (5.4.3). Practices that led to the abandonment of constructions of 'non-White,' culture also appear to have collapsed the binary oppositions of public/private and body/mind on which notions of the body as the object of view were founded. Accordingly, a midwife participant described how she recounted narratives of the experiences of other women to isolated, young Bengali patients. Similarly, an obstetrician participant described how she would recount her own birth experiences to patients from the population at large (5.5.3). These practices of paradigmatic storytelling were reported to serve to support patients' choices of options for maternity care. However, by emphasising personal experiences, these also suggested ways through which information-giving may offer a network of social meanings through which the transition to motherhood may be understood by individual women.

6.5 How do Arab Muslim women negotiate with symbolic maternal bodies in their accounts of motherhood and of birth in the London NHS?

This thesis has explored how various forms of knowledge of the body were used by individual Arab Muslim participants to relate their embodiment to notions of cultural belonging. Notions of the narrative self, the symbolic body and the relation of culture and embodiment were brought together using a feminist interpretation of the work of Merleau-Ponty ([1945], 1996, see 1.4.4) together with the work of Barth on the interpersonal construction of cultural identity (1.2; 1.3.3; 1.4.4). In this way, the thesis understood the embodied cultural self to be narrated in relation to a symbolic body and in relation to projected cultural difference. Similarly, the thesis proposed that individuals correlated their lived experience to the imagined symbolic body through using legitimate knowledge of the body (2.3). It further suggested that individual participants configured these natural-cultural relations to the world through narrating their experiences and suggested that individual embodiment might present fruitful grounds for de-stabilising dominant representative systems of women and of Arab Muslim women (1.2.4; 1.4.4; 1.8).

Across Arab Muslim participant groups, the construction of legitimate knowledge was used to imaginatively anchor the lived body in relations of belonging to its symbolic equivalents. Through such acts of narrative transformation, participants reconfigured the web of natural-cultural relations in which experience is established in order to transpose the boundaries of the national community and in order to incarnate links across time and space to their imagined places of origin (6.2). Through describing the construction and the uses of the category of 'non-White' culture, the discussion above outlined ways in which the accounts of health professionals reproduced colonial systems of representing women from Black and minority ethnic groups. By exploring the salience of the feminine body as the object of view, it has suggested that Muslim women migrants in London were represented by health professionals in terms of their non-subject status within the public sphere (6.3; 6.4). This final section will consider how the accounts of maternal embodiment provided by Moroccan, Yemeni and Iraqi participants served to challenge or to contribute to these systems of representing, 'non-White' and Muslim femininities and constructions of 'White' or 'educated' femininity that were configured around the *discipline* of the maternal body.

As was discussed above, narrative configuration enables the speaker to recast experience in narrating it (Ricoeur, 1988, see 1.2.1). Across Moroccan, Yemeni and Iraqi participant groups, experiences of pain and physical, 'openness' were represented as involving the loss of

cultural identity (4.3.2; 4.3.3; 4.4.4). Through the notion of bodily transgression as a source of natural-cultural danger individual Iraqi, Yemeni and Moroccan participants positioned their symbolic bodies and configured hybrid cultural selves in relation to these.

As suggested above, (6.2) Iraqi participants imagined the boundaries of the national community in London through, 'Muslim' maternal practices of the social and religious instruction of children. Participants described imaginatively projecting themselves into these practices through using scanned images of the foetus that served confer on it a distinct existence and that also served to objectify and externalise participants' own pregnant embodiment (4.4.1; 6.2). Through taking up a position exterior to the embodied self in order to defend the integrity of the national group, Iraqi participants appear to have represented the deterratorialised national group through their own bodies. Hence, accounts of the body in pain that were imagined to circulate among working-class and rural Iraqi women emphasised the loss of self in embodiment also served as *Carnivalesque* displays of cultural indeterminacy (1.4.2; 4.4.4). Thus, by describing experiences of transgression, by sweating, bleeding, or in the contortions of the body in pain, these accounts were suggested to invoke the loss of cultural identifications as women were reduced to a non-subject status in, 'being like an animal' (4.4.4). These strategies of claiming the status of responsible subjects through privileging the mind over the maternal body have parallels in the work of Amir-Moazami and Salvatore on the use of practices of veiling among second-generation Muslim women migrants in France and Germany (2003, see 1.6.5). Women's ostensibly 'Muslim' practice of veiling enabled them to contribute to national and transnational public discourses. Similarly, the construction of *responsible* motherhood through the willingness of Iraqi participants to objectify the maternal body may be seen to offer a strategic challenge to notions of the Muslim mother as a non-subject reported among health professionals. Nonetheless, Amir-Moazami and Salvatore also reported that professionally-active, veiled women of the second-generation criticised rural migrants, who wore smaller headscarves, for continuing to identify with rural traditions and for failing to differentiate themselves from the host society (2003). While covering the body was associated by health professionals with embodied identifications, within the context of social advancement in the migrant communities, it may serve as a parallel form of bodily *discipline*. Similarly, the claims of the Iraqi group to individual agency in the medical encounter were made through creating a class of *subaltern* Muslim women who were denied subject status through their identifications with transgressed embodiment (6.4). These strategies may be seen to reproduce health professionals' views that, 'educated' and prosperous Arab Muslim women enjoyed individual agency to the extent that they were culturally assimilated in notions of *disciplining* the body through decision-making.

Yemeni and Moroccan participants did not envisage a return to their homelands. Accordingly, their treatment of experiences of pain has been suggested to reflect a desire to establish a definitive moment at which women affirmed a cultural identity that was fixed in a network of relations of belonging to the homeland (4.7). By representing the embodiment of birth as an act of cultural affirmation, these accounts challenge perceptions that Muslim Mediterranean cultures associate feminine embodiment with shame (Brandes 1987; Peristiany, 1966, see 1.7.3).

The salience of embodied agency as a form of legitimate knowledge was indicated where migrant Yemeni participants described obstetric intervention in terms of passivity and second-generation Moroccan participant recounted examination and interventions through metaphors of sexual humiliation (4.5.2; 4.5.3). Within these accounts, the loss of embodied agency appears to have been used to fable notions of forced cultural integration (6.5). Conversely, by imagining their *resilient* embodiment to serve as links to homeland regions, localities and domestic contexts (6.2), these groups offered feminine identifications that were constructed outside binary representative strategies. By delimiting identifications with pain through the narrative form of storytelling, such representations resist the ascription of an *abject* status to maternal embodiment. Accordingly, through establishing the feminine subject in a natural-cultural continuum, these representations of rural and working-class Arab Muslim femininities in Britain thus extend fertile potentials for developing non-dualist femininities to other Arab Muslim groups and to the population at large.

6.6 Recommendations

The findings have illustrated the diverse constructions of legitimate knowledge through which participants sought to understand their embodiment. Despite the diversity of these strategies of constructing the symbolic body among participants from the Moroccan, Yemeni and Iraqi groups, some common patterns in participants' needs for maternity information should be stressed. While some of these needs may be addressed by individual health professionals, others suggest wider policy changes and demand further research. This section describes how each of these may be addressed.

Recommendations for health professionals

1: Embodied sensation during labour may represent a crucial source of knowledge of progress through labour and birth among some Arab Muslim groups. Accordingly, choices to postpone pain relief among Arab Muslim women should be supported where possible.

2: Given the widespread belief in the body mind continuum that links maternal wellbeing to the safety of the foetus, care should be taken to avoid giving unnecessary information to Arab Muslim women on risks during pregnancy and birth. The patient's needs for information should be ascertained by directly questioning the woman herself. Similar steps should be taken in the case of visual information.

3: Where Arab Muslim women are not able to easily communicate in English, time needs to be taken to ensure that they feel entitled to ask questions concerning their state.

4: Health professionals should be wary of the ways they may relate to Arab Muslim women through perceptions of low educational attainment and low social class.

5: Health professionals who are themselves migrants or who come from Black and minority ethnic groups should in no way consider themselves as less liable to exclusionary practices.

Policy implications

1: Following from work on the uses of discourses of patient autonomy to withdraw the boundaries of medical responsibility that has been discussed above (Salmon and Hall, 2003, see 2.5.2), health policy needs to examine and distinguish the institutional and therapeutic functions of devolved decision-making.

2: Given the culturally specific nature of the construction of information for decision-making, the use of individual accounts of pregnancy and birth should be encouraged in cross-cultural communication with Arab Muslim women.

Suggestions for further research

The thesis has suggested that Arab Muslim women were perceived by health professionals to represent essential and disruptive difference in NHS maternity services. Given the intimate relation between constructions of, 'Muslim,' culture and health professionals' professional and personal identities, the extensive representational apparatus used to impose identifications on this group and other Black and minority ethnic groups needs to be dismantled. Accordingly, questions arising from the study that may be productively addressed in further studies relate to:

- How do perceptions of decision-making in NHS services serve to construct gender and cultural identities?

- How may discriminatory practices in information-giving be justified through notions of the self-responsible agent?

- How do health professionals' perceptions of the use of information relate to their own gender and social class identities?

- How do perceptions of the hospital space provided by maternity health professionals and patients reflect constructions of authority, knowledge and embodiment?

- How do accounts of maternity decision-making provide a means for Arab Muslim women to relate to notions of British identity?

- How do the maternity accounts of Arab Muslim women of the homeland or family homeland reflect ways of locating themselves within British townscapes and landscapes?

- How do migrant groups other than Arab Muslim women use knowledge of the maternal body to imagine links to homelands or family homelands?

A final potentially rich area for further research relates to the constructions of legitimate knowledge of the body as this may suggest patterns of imagining local, regional and domestic origins among rural-urban migrants in the Arab world.

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Appendix i Focus Group moderator's guide

Preamble:

Thank you all for coming. This session is meant to record the views of all of you but if any of you wants to stop at any time, you are welcome to leave the room. If someone has a different opinion from yours, please respect what they have to say and do not try to speak at the same time as them. Because what you say will be used in my research, I will be recording this session. When I write what you say, I will give you different names so that nobody will know it was you who said that. But I do need to ask you not to talk to other people about what the other women say during the session. The interview should take one hour. So that we finish on time I might need to interrupt you at some points but this doesn't mean what you are saying is not important. (Switch on tape).

I'm going to read some things that other women have said about information and about being a mother in London. After each one I'll ask some questions, so that everyone can talk about what they think.

Story 1:

A woman from Yemen was describing what it meant to her to be a mother:

To me, it's someone to love. Always, I want to buy things for my daughter. But I think about her all the time, especially in this country because you hear things about accidents and murders. I will not stop thinking about her, if her life is good...Not [now] when she is 16, but when she leaves me to start a new life. That's the difference between me and English women. I work, but I am always a mother – no holidays – no time off (first focus group – incomplete tape not used).

What does it mean to you to be a mother?

- Is being a Muslim a part of being a mother?
- Do you think being a mother is different for women who aren't Muslims?
- Would it be the same if you're family had not moved to London?
- Can you think of someone who is a good mother?

Story 2:

I asked a Somali women how she wanted to know about problems she had during her pregnancy and she said:

I might ask somebody who'd had the same problem for their advice. But not just to read [leaflets]. It gets too much. They [the other women] know as little as me. But when there is something wrong with you, you talk about it and it makes you feel better. In general, when I'm pregnant, I trust what my friends tell me. I can get more detail and even argue with them because they speak my language. But I want them to get information from the doctors to tell me! My English is still not good and with my last labour, my husband couldn't be there. At first I didn't understand what they [doctors and nurses] were saying but later I got to understand what they were saying about me – if it had been too long and to call the doctor. I felt happy to know something (Khadiga FG – collected for MSc. Project)

If you had a problem in pregnancy who would you ask?

What is the best way to find out about being pregnant and having the baby?

- Talking
- Reading books or leaflets
- Videos

Would you want to find out about things in pregnancy and birth if there was no problem? If so, why would you want to know?

- To think about the baby
- To think about how the pregnancy will be later
- To think about being a mother
- To avoid being worried
- Just to know.

Story 3:

Another Somali woman I talked to didn't speak English had her baby when there was no interpreter. She was frightened of having a Caesarean and she hadn't asked her doctor about how it would be for her. She told me:

You're afraid for your child and if you don't understand what the doctor is saying, you worry. I wouldn't have asked. In hospital when I was in labour, I tried to work out what was happening from watching what the doctors and nurses were doing. It [labour] was going on and on and I didn't know why. I knew something was wrong but nobody tried to tell me. When they went to change their uniforms, I knew I was having a Caesrean section because at home [Somalia], they do that too. I was shocked and I was in tears. Afterwards they said it was an emergency – that the baby would have died because all the water was gone, but I hadn't wanted them to do it. It was all what they wanted to do (Naima - collected for MSc. Project).

Do you think what happened to this woman happens to other women?
Is it normal that she was upset and crying when she guessed she was going to have a Caesarean?
Does it make you feel better if you're told everything that's happening when you're having your baby?
If something needs to be decided, who should decide?

- You
- the doctors
- both
- does it depend?

Final question to be asked to all groups:

How is life in London different from Iraq/Yemen/Morocco?

Thanks you very much for taking part in this session. If you would like to contact me or to add anything to what you've said, I would be happy to hear from you.

Myfanwy Davies

Address:

Telephone:

Appendix ii Interview guide for individual interviews with Arab Muslim participants

Story 1

A woman told me:

'The mother has to be all-powerful, all-knowing...and to be a mother happily and confidently, we need to feel the baby is our responsibility. I have learnt that women need to talk as equals with doctors, to be informed of the choices open to them and encouraged to make up their own minds...I've discovered how important it is to be in control of the birth experience if she's going to emerge as a confident parent...

Paraphrase: If you're going to be a good mother right from the start, you have a good birth and to have a good birth, you have to trust the doctors.

Do you think this woman is right?

Possible prompts – Depending on the participant account given

What did you want to know from the GP when you were first pregnant with you first child?

- risks,
- tests,
- expectations.

What did you want to know in the last few months when you were expecting to go into labour?

- What kind of delivery to expect
- Who would be there
- Would there be cutting involved
- What kind of pain relief you might take?

What information were you given when you were first pregnant with you first child?

What information were you given when you were expecting to go into labour?

Who gave you this information?

When you were talking to doctors and midwives/nurses, did you get all the information you wanted from them?

How did you decide what information from doctors and midwives/nurses was good?

Did you feel you could ask for more explanation?

Who do you think should make decisions in labour where things are going as they should be?

In an emergency, who should make the decisions?

After the baby is born and everything is fine, who should make decisions about feeding?

Story 2

A midwife told me:

If all this information seems like a lot of work, remember you own it to yourself and your baby to be well-informed and accurately informed.

Paraphrase: Looking for information is hard but to be a good mother, you need to do that.

Do you think looking for information from doctors and midiwives/nurses is a duty?

Should they know what to tell you?

Possible prompts

Did you want to be able to decide everything the doctor and midwife/nurse did to you in labour?

Did you decide before about pain relief?

Is it important to have a memory of what happens in birth?

Do you miss something is you don't feel birth?

People talk about birth being an important experience, was birth important – or was it getting the child in the end?

Story 2

A woman told me about using information to decide on what she wanted in her birth:

I knew I wanted a natural birth and from when I was pregnant, everyone was telling me what happened to them. So I felt I had the benefit of their experiences. Some of them, I think, had particular reasons for telling me what happened to me – either for or against doing it naturally – but mostly for. They told me about the pain – and although it was very

bad – because I knew the other women had gone through it with the breathing (method they teach you), I really argued against the gas, even though I felt pressurised to take it. No amount of figures could have helped me. I know I could take the pain because the other women had.

Was there something someone said that helped you understand what was happening in labour? Did you have a big idea about birth before you went in to hospital? From your mothers or your friend?

Possible prompts
What helped you decide what you wanted during labour?

- Your mother's stories or your friends'?
- Doctors' or midwives'/nurses' advice?

If you had to decide on something – can you describe how you did that?

- Who told you there was something to decide?
- What other things did they tell you?
- How did you decide what was important to know?
- Did you think about the danger to you or the baby?
- What did you decide in the end?

Final Questions

- ***to be asked to all participants who haven't dealt with these in accounts***

What is it that makes a good mother?

- Does the experience of pregnancy and birth change the relationship you have with the child?
- Do you think it would be the same for English women who have another religion?

Why do you think women tell stories about being pregnant and having their babies?

- What are these stories about?
- What stories would you tell? (Why?)

Appendix iii Interview guide for health professional participants

The uses and construction of information

1.1 How important is giving maternity information to women in terms of promoting responsibility?

1.2 What would you say is involved in communication between health professionals and women?

1.3 In your opinion, is there a link between a birth where the woman has good communication with health professionals and her confidence as a mother?

Information needs of women

2.1 What do women want to know when they first know they are pregnant?

2.2 Have women discussed non-clinical issues with you? If so, why do you think the discussion arose?

2.3 What do women want to know when they are approaching labour?

2.4 Do you feel women ask as much as they want?

2.5 Do you think women have more confidence in information given by certain types of health professionals?

- Does this depend on the type of information sought?

2.6 How do you decide what information to give a women?

- Does it depend who else is there? (- health professionals or the woman's family?)
- Does it depend on her receptivity? (- is this related to using translators etc.?)

2.7 Does the degree of shared decision making you offer change?

- Does it depend on the gravity of the situation?
- Does it change after birth? (-for midwives?)

Interpersonal knowledge for women

3.1 Do women ever suggests to you stories they've had from friends or relatives?

3.2 How important would you say these are when women are making decisions about their care?

3.3 Do you think culture plays a part in what women want to know about pregnancy and birth?

3.4 Do you think culture plays a part in women's expectations of birth? (- for a first birth or after?)

Motherhood and culture

4.1 Do you think ideas about motherhood are different in difference cultures?

4.2 Do you think there's a concept of the Arab mother or the Muslim mother?

- If so, how would you describe them
- How might they be different or similar?

4.3 In you experience, what makes a good mother?

Storytelling

5.1 Why do you think women tell stories about their pregnancies and births?

- What are these about?

Appendix iv Example of Validation stories

GP1: Validation Stories

Story 1: Information and control as bases for patient responsibility.

A level of information is a necessary starting point for taking responsibility in pregnancy. Where this level isn't reached, you are starting from a position where the woman has no control. Women need to feel the pregnancy is their responsibility or they will feel that on this conveyor belt that goes on no matter what. As a doctor I see myself as a translator. Quite a lot of the information giving I do initially is to do with complex decisions in maternity care, to do with risk perhaps, that lay people don't necessarily have an understanding of at the outset. A lot of people feel quite overwhelmed by written information so I try to put it in a form that's more accessible. A few basic principles are useful to them to hang their hat on.

Screening is a minefield. You don't know the couple well enough most of the time to know what course they'll want to take. So you have to weight it up for them X vs. Y vs. Z, without necessarily knowing. But for your population, they might well not take the tests. I would always bring it up, and I've never had anyone offended. I think as a principle, women need to be given the opportunity to say 'I don't want to know'. But there is a group that wouldn't take it up, yes. I think in general when there is a problem with certain treatments – that they turn out not to be what they want, if you give them all the information, you can usually negotiate ways out of it. Patients need to know they have these choices to take responsibility for how they use the service, but also for their child.

Story 2: Medical information as a means of preparing women for birth and motherhood.

When you give women information early in pregnancy, I think it does help them prepare for delivery. I mean at the booking appointment you are talking about delivery options so you're already asking women to consider 40 weeks. At that stage a lot of the discussion is about logistics like where to go for delivery. But almost inevitably once they've made that decisions, they go off and look up other information as well and that opens up new vistas

for them. When they do that varies a lot. For some women thinking of themselves as mothers is a very natural process but for other women it's really shocking. You get the impression that they're climbing mount Everest everyday. On the whole, pregnancy is a really good time to give information about general health issues, because women are much more turned into their physical state. So in that respect maternity information is about taking responsibility for health in all sorts of ways.

Story 3: Interpersonal issues in women's seeking of information.

It's peculiar how much of a range of attitudes there can be among pregnant women. Some women bring these long lists of questions and for others it's like a blank page. Really it's like it's happening to someone else and that in itself can be satisfying because with each thing you tell them you feel you're switching on a light in the house. Other women are terrified about certain hospitals or want a certain kind of healthcare that their friends have had. Older women can be obsessed by screening. And then there is a little group of older women who are having their first and for them they have to balance the risk posed by screening to this precious pregnancy against not knowing if everything is OK. Then there are women who are just happy to be pregnant and who want to be part of that. They bring the news like it's a present, but they don't really want to know anything. Another thing is that in pregnancy and just after, women sometimes want to sort out all the other aspects of the transition. Often though it's just to do with checking if it's normal, lots of women discuss sex before or after (birth). But certain women would never do that. I think it's to do with being a health professional because I'm sure they do discuss that among themselves. Working women sometimes realise quite late in pregnancy how they will have to organise themselves around the child. Then the list gets really big. They seek me out – and really it's for totally non-clinical things - nannies, work, dummies, mixed feeding, the use of extended families for childcare and sex again... It's fine with me because that experience is all quite fresh in my mind. On the whole just as you come up to labour, like most doctors, I try to encourage women to think about the delivery so they know about pain relief and can make choices about it before they are actually in labour. Some women do abuse information giving though. One woman took hour in the consulting room and later she sent me a list of points for clarification! Another, and that was a classic, had a list of 32 questions, 24 about herself and 8 for her baby.... Both times I sent them off to one of the big bookshops. You can browse and the big ones have cafes where you can read. I also tell them to read *Emma's Diary*, which I think is excellent.

Story 4: The GP in information-giving, difference in expectations and warning stories

I think that most women trust the information given to them by their GP or the practice nurse, because they feel they are known to them. I can't really say how it works along ethnic or class lines but what I've noticed is that women who've had lots of babies do develop very strong views about the care they want and the information they want. I think that this must be based on wanting to avoid previous bad experience and to duplicate good experiences. They often take a strong dislike to hospital midwives, I suppose because they don't know them. But they get it in the neck. I don't think that it's to do with cultural expectations either really. I mean all women think their system of health care is the best because they're used to it. So I don't think it's a problem with midwife-lead care so much as personal issues. If someone is seen as being nice, that over-rides differences in expectations. I think the key is good communication, but labour is not an easy time to practice that!

Women do have their own ways of getting an idea of the care they'll get and they'll often tell me about these stories like they are 100% reliable and a lot better than evidence-based practice. It's because they trust whoever told it and it's a real life story. They've got a certain entertainment value as well 'my sister's neighbour had a terrible tear' and they're almost always a bit sensational. The other ones are more basic types of advice, like on which hospital to go to. One patient I saw changed her hospital preference on her half-sister's advice and another one chose to have a caesarean section after hearing a story about a good outcome for a friend of hers. The patients had had a horrible first delivery, and I think that was absolutely the right decision for her.

Story 5: Culture and making sense of birth and motherhood.

I wouldn't want to say anything about the significance of birth in different cultures. It's not something I could really comment on but I think different cultures do have different expectations on how a woman behaves immediately after giving birth. I mean you might be expected to receive all your family or you could be expected to stay in bed shut in a room

without moving. I've had some experiences with women who think that something you do has a benign influence. I've even heard that other doctors are meant to be malign – but obviously if I was, I wouldn't see them again! I think in general, talk to their partners about how they will go about parenting their children. I remember we did this by choosing certain role models or aspects of other people's behaviour. I mean for example with matriarchal family structures, you would have a set mother pattern. For me culture is where the head is, but where you have a very mobile population, you can't watch how other women do things, so I think you have to adapt and improvise. But I think that a lot of cultural patterns get passed on, totally without you thinking about it. My family is Irish catholic and we are very matriarchal in a way. When we get together with all the cousins, you notice that the children turn to any available woman to be mothered. The strange thing is that we never intended that, it was something that the children initiated themselves but I suppose we've brought them up with certain similarities in the ways we've socialised them. They're very communal.

The question about good motherhood, is a hard one to answer. I don't really feel it's something you can be proscriptive about, but I suppose what I aimed to do was to be consistent so that my kids would know the limits on what they could do without my being controlling. It's something I thought of myself when we saw it in other families, and it works because it lets us be more relaxed with them. I didn't really talk much to my mum about the practical stuff of being pregnant, because I think with my professional background she would think I didn't need that. I used to work in paediatrics and saw a lot of parenting under difficult conditions and I've got an enormous amount of practice in looking after my friends' children who are all older than mine. So I was fully trained for it. I think in general, women tell stories to recognise what this incredible personal experience means to other people and so that you get recognition from them. These days most of the stories are about funny things the children do. You tell them because they make you laugh and because you're proud of how your kids are growing up.

Body/Knowledge/Identity Own uses of information/ storytelling and views of patients' uses of same	Maternal body related negatively to non-white cultures Knowledge = Evidence-based. Identity = Rational Individualist	Body-Mind continuous. Knowledge = culturally determined. Identity = reflected by peers in storytelling	Body-Mind continuous. Knowledge = experiential. Identity = Formed by peers And by experience of birth.	Body-Mind continuous. Knowledge = embodied. Identity = Rational individualism critiqued for false belief in 'control'.	Bodily processes acted on by service. Knowledge objective, not contextual. Identity = Rational Individualist Culturally neutral.	Emphasis on bodily integrity for white women. Knowledge = evidence-based and narrative. Identity = embodied grounds of identification with white patients	Patients' bodies not represented. Knowledge = evidence-based and visual. Identification with professional role. Motherhood as relation to NHS service	Body = as property of self. Resistance to 'culture'. Knowledge evidence-based and narrative. Relating to white educated patients.
Own anecdotes for recognition along class/ethnic lines								
- for patient autonomy								
- for 'responsible' motherhood								
- for orientation to service								
Storytelling for social recognition and information (HPs peers)								
Storytelling for recognition/ information (all women)								
Storytelling for social recognition only								
- to project – pain/choices								
- for decision-making								
- in diary book to imagine embodied change								
- to adapt to social meanings birth/motherhood								
Storytelling as malicious								
Storytelling as ideology among non-white groups								

Appendix ix - An example of a Yemeni participant's transcript

Individual interview with Y6

INT OK, this midwife, she was talking to me and she made this comment.

Y6 Hmm

INT And I thought it was interesting because she says a lot of things in a very short space, yes?

Y6 Hmm

INT And I wanted to know what other people thought of it. So she said (reads story 1) responsibility..

Y6 yes

INT equal with doctors...

Y6 yes

INT Now she says, sort of, three things. She says about needing to feel the baby is your responsibility. Now do you agree with that? Do you think that's true?

Y6 Yes

INT What about this thing about women needing to be equal with doctors, do you think that happens?

Y6 What does it mean 'equal'? To help them? They have to be with the women -with us...

INT They have to have the same respect for you that you have for them?

Y6 Yes

INT Do you think that happens? That's not a problem?

Y6 No, no, no problem. I was a lucky woman really.

INT Good, I'm hearing only good things today. (Both laugh)

Y6 I was lucky with three pregnancies and I was so lucky with the midwife, the doctors...Some women, my friends, they say 'you are lucky, but we are not'.

INT Hmm

Y6 That's why I'm coming to say about this. Or something they don't tell us (if I tell you) it's something they can do in the future for the other women. Because to be a mother (is) very difficult, you have to know, with the first one, how to wash it, how to...because when the baby's born, the mother will have the distress. (tape switched off for child)...They have to help her as she grows (as a mother) with the baby. She has to have more...midwife or the nurses...they have to be more with

the mother than the baby. But here they look after the baby more than the mother. You know when the baby is born, 'oh take the baby'. They can't just look after the baby.

INT Do you think that's because, if you look after the baby, it's quite straightforward. You give the baby care whereas if you look after the mother, you have to talk to her?

Y6 But that's it, they have to talk to her. (They have to) tell her, 'don't worry, it will go', help her with the breast feeding. No, when the baby is born, she doesn't want to breast feed the baby, why? Breast feeding is very important for the baby, the baby will be...doesn't have any sickness or illness, doesn't have any excema. Now the scientists and the doctors are saying it's very, very important to breast feed the baby. I breast fed my three babies, and they're healthy and they're very good. And with the food: they have to give them, natural food, buy from the shop, cook it and give it. Not everything you go to the (supermarket) because they're cooked and very easy and packed in the tin and give it the baby.

INT But the other women don't know all this, you think?

Y6 No, they have to educate them -give them a lot of things to know what's going on. Some of them, they don't know really. They give the baby, just what's easy.

INT Hmm

Y6 Milk in a bottle and give it to the baby? No. They have to tell them that breast feeding is very important. Not just to have a baby, the baby needs a lot of things, really a lot of things.

INT And they don't know all this?

Y6 No.

INT Do you mean Yemeni women more than other women?

Y6 Yes and no. I mean at home, you would do the good things out of habit. But they don't know why breast feeding is good, so they change when they are here, with all these easy things - foods and milk in the shops.

INT OK

Y6 Especially, the breast feeding. I'd like all women to give their babies breast feeding.

INT Oh, yes. OK, when you were first pregnant with your first baby - if you remember..?

Y6 I was, I was (laughs). Well it doesn't matter much because they came so close (both laugh)

INT They seem to be. What did you want to know then? So with your first baby, were you thinking about risks, or what to expect or more general things about motherhood?

Y6 yeah, about how to be a mother. How to be a good mother. What I have to eat to have a healthy baby and how, how I will bear this baby.

INT Actually how you would do it?

Y6 yes because I was scared. Everyone was 'ooh you will have a difficult labour, you don't know how to do it'. But I would like to say to all women to go to the courses and ask experienced woman who have three or four babies and they will tell her. Because all woman, she (they're) scared how to bear the baby, because of the pain, but the pain was maybe five hours or three hours, but if she's got experience, if she sees films or has it explained to her, it will be maybe easier for her or she will bear the baby very easily.

INT OK. Is it important to know what to expect and to stay calm?

Y6 Yes. ...to know if it's a boy or a girl?

INT No to stay calm.

Y6 Yes

INT Oh, no - to know what to expect in terms of how you will give birth, what will happen to you, what will happen to the body, how the baby will come out. Is it important to know that?

Y6 Yes, it is very important thing because when she is in labour with the baby, the pain is such, that she doesn't know what's going on. What will happen, because the mother always wants just to save the baby. She doesn't want to know what's going on for herself.

INT Yes

Y6 She says in her mind,' my baby', (she may be) crying or whatever, she's so worried. 'What's happening', 'where's my baby', 'is the baby coming'. It's very important to know how the baby will be born. And she has to do all the exercises they say in the hospital - the courses they give on exercising. She has to know all of it.

INT Ok, so when you were coming up to labour...

Y6 When?

INT With your first one, say you were seven or eight months pregnant. What did you want to know then?

Y6 I want to know, when the baby would be born. I had to learn to be patient, not to worry about what's going to happen. She's got the ambulance number, she's got the GP's, she's got the emergency number. Don't be worried, be patient and wait and be patient for the pain. It is really painful -I'd be lying if I said it wasn't - but you have to be patient with the pain, because you want to have a baby (both laugh).

INT Exactly...and when you were having each of your babies, and you're sitting in the GP's surgery having just found out you are definitely pregnant, what information did they give you? Do you remember? Did they tell you, for example about foods, about risks...?

Y6 yeah, they told me everything about being pregnant, and they gave me a booklet about how to feed the babies (what to eat?). But she doesn't sit there with me and explain a lot of things, no. She just gave me a book (is agitated) and she said 'go home and read it'. 'You're pregnant, be careful' (laughs). yeah, that's it.

INT Were you a bit disappointed?

Y6 Yeah, I was disappointed, I would have liked somebody to talk about the baby, about afterwards, how the baby would grow. We need help at that stage, they have to talk with the lady really, about all these things.

INT Especially with the first one?

Y6 Yes, the first one is very important.

INT Did you talk to your mother a lot when you were pregnant?

Y6 Yes, I was lucky, I had my mother always with me. But a lot of women they are not. They know just ,' where's the baby', they know so little. Especially, the girls, sixteen or seventeen, they don't know anything. They say, 'I've got a baby', or, 'I'm pregnant', and you have to encourage them, because there is so much to know.

INT But is it just, things to know or that you know someone will support you?

Y6 Yes, the women has to have somebody with her, her husband, her mother, her friend (to) talk with her, go with her. Ask about it; have experience. I would like to have a course for women who start to be pregnant, or who want to be pregnant. Maybe in the hospital and talk about it. Not like the girls who say 'it's so nice I'm pregnant,' but they don't know what's going on. The courses they have start when the baby is seven months and that's so late. She has to know when she needs to decide to have a baby (before conception). She can have the books. She can read the books, but if she talks to experienced people, it's better I think. Because she need to learn how to bear the baby - the book is just reading, but some people, they can show you the actions and you can ask them everything and they will give you an answer.

INT Do you think it's also not so much preparing for the birth, but thinking about what kind of mother you will be?

Y6 Afterwards?

INT But do you think you should consider it during pregnancy or should you just concentrate on the baby being born?

Y6 Yeah, the women has to know everything about what's inside her. How to draw this baby inside her. How to eat a lot of fruit and vegetables, not being nervous, but knowing what's happening. And

they have to help her really, someone to stay with her and help her especially the husband, boyfriend, mother, father, the people who are important to her.

INT Hmm, but you know you talk about the stories other women tell? Do you think sometimes they can be a bad thing - because if somebody's had a bad experience, that would make the woman very afraid?

Y6 yeah.

INT Do you think then that the women shouldn't tell the stories?

Y6 it makes women very afraid. One time I saw a lady in the GPs and she was pregnant in the first month, she was scared, she didn't want the baby, her whole life was over, she thought. And she was saying 'I don't know how o bring him up', she didn't know anything. But you have to know it's a good thing, I was talking with her I was saying, 'you're going to be with your own baby'. But she was saying 'I don't want a baby, I don't want a baby'.

INT So she wasn't prepared?

Y6 No, not at all. She'd even tried to push to miscarry the baby. She didn't know how to carry the baby, she didn't know anything. I say, the women, she has to know (other people's) experience, before she has the baby.

INT But if the experience is bad? If someone tells her about a bad experience?

Y6 It will be so bad for her, because she will be so afraid. They will think all the time about what happened. Like...these things, they hurt the baby, the baby becomes nervous (pause) not right (for) baby, you know because, the blood...All things happen between the mother and the baby, this is why the mother has to be all the time happy, relaxed, enjoying so the baby will be happy. If not the baby will be not happy, maybe something happen, maybe she lose the baby. Don't give pregnant women bad news, always be calm and talk about it. it happened with my little one. I was in the hospital, they give me a student. They send me a student to see my baby. She (the baby) was thirty seven (weeks). She (the student) might have misheard and thought I said thirty five (weeks) and she said to the doctor, she said, 'her baby is small'. And the doctor said 'oh, I'm sorry', and I was sitting there with my husband. But it was them who didn't know what was going on. They said, 'your baby is thirty five weeks', I said, 'No, I'm saying, It's my baby and it's thirty seven weeks'. So the...the doctor says, 'oh, I'm sorry', I said, 'you're not sorry, you sent me a student. You were not with her in the room'. You know what I mean? But nobody listened in the hospital, nobody ever does listen and that's why I was so worried. I don't want to have to ask somebody about what they're doing all the time. they have to know that if they send a student, there has to be a doctor with them.

INT So that you feel they will give you the right information?

Y6 Yeah.

INT OK, when you were talking to doctors and midwives in the hospital, was it easy to ask them things that were worrying you?

Y6 yes, it was easy.

INT But..

Y6 you have to have the question you want to talk (about) with them. They don't offer anything. they say, 'you're fine', 'You're OK', take care', and that's it. I say, you have to have the question you need.

INT You said about this student who gave you the wrong information about the baby's size?

Y6 Yes. She has to know. My tummy, she took my tummy to say how big the baby was. And she saw the book I gave to her with my details. I don't know what she was thinking, but you can't guarantee against that. What should happen is that (they) don't leave the student without the doctor. Don't leave the student without the doctor (is upset).

INT yes, of course.

Y6 because the student are new, they're new to everything. She left me and she went to see another woman.

INT But after that, how did you decide if what they were telling you was good or not? Because you might have felt less confidence in it then?

Y6 yes, all this time I was so worried. I didn't know what should I tell them. because they told me the baby is small for its age, I thought 'why'? I was here last week, they told me everything is alright. And then she was writing that I was thirty seven weeks and I was saying, 'I'm not thirty seven weeks, I'm thirty five weeks'.

INT But after that, did that mean that you trusted the doctors and the nurses less, because this had happened? Did you think, ' I'm not sure if what they're telling me is true now'? Did it effect you like that, or did you think, 'well these aren't students they know'.

Y6 yeah, I'm saying that because they are students, they don't know. The doctors and the midwives have experience, so they know.

INT So, usually, you would trust what the doctors said?

Y6 Yes, almost always. In fact, I've always listened, although I can imagine a situation when I wouldn't, because sometimes you believe things about how your child should be raised and the doctor might disagree.

INT Why would the doctor disagree?

Y6 Oh, I don't know, about all the time I spend with them maybe. You know they don't play so much with other children and foods..

INT OK, when your friends were talking to you about their babies, how did you decide that those stories were good? I mean some women, they say, my friends tell me stories but I don't think they're accurate or as complete maybe as what the doctors say. But they trust their friends more. Did you think of it in a different way?

Y6 Well, it is different. That is their experience, and its important to them and to you, because they're your friend, but it....I don't know. You know all women's have got different bodies, this woman I know has got big difficulties in having the baby. That's why I'm saying - they're different. The doctor might say to one woman, you've got a good body for having babies, they will be strong, but for another, it won't be like that. You know that some women, they have the baby (by) caesarean, some women, normal. The body is always different.

INT So when you had your children, you didn't have any problem?

Y6 No, I didn't have any problem at all with my pregnancies or any problem when I had the babies. I had good midwives and I asked them about everything, and I read a lot of book before I became pregnant and before I had the babies. And I was Lucky my mother was with me, she's got experience and she answered a lot of questions like what should the pregnant (woman) eat? it's a very important thing because of how the baby grows. Not eating because I want to be slim, I don't want to be fat. This is not good, it doesn't help. You need to think of the baby and also eating vegetables does not make you fat. You need to think about the baby, not eating because you don't want to be fat, is wrong.

INT OK, so you had no complications?

Y6 No, but my friend, ***,when she went to have her baby, they put her in a room and they left her. And she was alone, she's got nobody to help her, come down, to help with the pain. After one hour, she went to them and asked them for help.

INT Hmm. Back to your labours, yes? Did you have to have pain relief or anything like that?

Y6 No, no

INT Nothing at all? (laughs)

Y6 Nothing. they wanted me to have something, but I preferred to have the baby in the normal way. it was painful, but after the baby is born, you know it - you know when it was. This is the good thing, when you have the baby with the pain, you will know.

INT So you wanted the pain in a way.

Y6 Yes I wanted it.

INT Because that was the sign you had become a mother?

Y6 yeah, yeah....Because if we ask our mothers, they didn't have any painkillers. All the time they bore the baby in the normal way. We forget how it was before because we're so used to having this and that. Now the opinion of all women is that we don't have to feel the pain, 'give me the gas,' 'give me the injection'...

INT But that's not good?

Y6 No, you shouldn't be able to stop feeling your baby like that. It's what you should bear for your child.

INT Did you feel that they pressured you to have the painkillers?

Y6 No. Three of them, they told me before 'do you want something', I said , 'I don't want anything, I want to bear the baby normally', and they understood. the midwife was my friend.

INT Good. I don't want to ask you all these or we will be ages. (pause)...I was talking to a midwife, who teaches other midwives, and she said this which I thought was interesting, because it says a lot perhaps about the attitudes of midwives. She said about looking for information (reads story 2). Now do you think that's true? is looking for information a duty, or should it be something women are provided with?

Y6 How to be a good mother and well with the baby?

INT To look for information on being a good mother.

Y6 Yeah, this is very important thing.

INT But should you look for it?

Y6 I think the midwife must tell her, explain to her what's a good mother. Some women, they don't have anything. Maybe some women, they don't - can't read. They want to listen, she (midwife) has to tell her, to know what's going on.

INT But does the midwife have to know what the woman will want to know?

Y6 Yes

INT OK. When you were pregnant with any of your children, how important was it to you that the birth itself should be good? For example, you said that you wanted to feel it the whole way through? So, was it...did you have expectations about how exactly it would be? Was that important?

Y6 yeah, yeah. it was for me. Experience for me was precious because that was the point I knew. The pain, when the head is coming out, that is just the hard pain. That's it, it's over. But if she do the exercise they tell her to do, she will come through.

INT Do you think that experiencing that pain, generally is important for becoming a mother?

Y6 For me, yes. But some women, they say 'no' because they fade a bit, so for them, no. But I say, for a woman who wants to be a mother, she must expect everything. She has to believe she can to it, she has to say to herself, 'I will be a mother, I have to accept all the pain'. She will be a good mother, if she doesn't say this thing to herself, she will never be a good mother. She will never look after the baby, when the baby is born she will be able to ignore it.

INT What do you think it is that makes a woman a good mother? Is it responsibility?

Y6 Yes, it is. She has to believe what the baby is, how it will grow, how her body needs to help it.

INT OK, and why do you think women tell stories about being pregnant and having their babies? Because women do when the get together, they're always telling stories about it, why is that? Is it a social thing? Is it because everybody has had this experiences or...something natural, the woman she want to know first of all, what's going on. This is good for her to know.

INT But what about women who are not pregnant - who've had their babies? Why do they tell stories?

Y6 Sorry?

INT There's a group of women, none of them are pregnant at the moment - they might be pregnant again - but none of them are at the moment, and they're talking about having their babies...

Y6 Second baby or first baby?

INT Maybe their first baby. I mean why do women like to talk about it so much?

Y6 Because it's a natural thing God gave to the women.

INT So that's an achievement?

Y6 Yeah, because she wants to be a mother in the future. God gave it to every woman, and this thing belongs to her body and to her heart to be good mother.

Appendix x - An example of a Moroccan participant's transcript

Individual interview with M2

MD What I'm going to do is that I'm going to read you the words that other people told me about information or having their children and I'll ask you what you think about what they're saying.

M2 In English or Arabic?

M1 (Explains in Arabic) Sweetheart, she'll do it in English, because we don't have any more time to translate. But if it's hard, I'll translate for you - and your answers too. Are you happy with that? If you like, sweetheart, we could just do it slower and I'll translate everything?

MD We'll still need to translate afterwards - to get all the words.

M1 That's true - (to M1 in Arabic). How about we do it in English then?

MD I mean in English if you can but... (in Arabic)

M2 (in English) No, no, that's fine. But who gave you the questions? Yanni, who do you work for?

MD They're my questions, I work for the university, but really just for me, because this is my study, with my teachers.

M2 Oh, I thought, these women (whose words are in the stories)

MD Oh, no, but the words they're saying - most of them - were from talking to them for this. So the midwives, they're mostly English midwives, and the women I talk to are Arab women... But I think that most of the stories here...let me check...there are three stories and two of them are what midwives said. So they were told to me in English, but the last one was a Yemeni woman and that's translated. OK, so, this midwife told me, ah, (reads story 1). So do you think what she says is right?

M2 Yeah...I mean when the child comes into the world, a lot of it is about pain, the pain of carrying the baby, the pain of giving birth, there's the staying up all night feeding. And as well, when they grow up, you worry that they'll grow away from you. So because of that the mother, you know, she has to be in control, she has to know what she's doing.

MD And do you think that's to do - is the relationship between being in control, being strong and the kind of birth you have- is it important to have a good birth?

M2 Hmm, when I knew I was pregnant, and I thought about the pregnancy, I knew what was...eh...following after that. I grew in confidence the same time my baby was growing.

MD Do you think that's because it became easier to recognise what would happen?

M2 Yes, and because you realise you are two and you realise it has to happen. You know the last one (by the first husband), she's going to be thirteen now, she's still like a baby. I still look after her just the same (laughs).

MD is that because she was the littlest?

M2 you know the other night, she said something that made me laugh, 'I'm the number 1' she said. She still is. And you know it's my birthday today, and she made the cake for me.

MD It's your birthday? Oh happy birthday - -what are you doing here - with all these other women? (both laugh)

M2 Well, it's my birthday, so I thought I would see my friends. It's normal, after all my birthdays are not so much fun at home. The children can't imagine how old I am (laughs). But my daughter, she made the cake for me. She went to the shop and she bring everything, she put the chocolate on and the cream and everything. I said, 'what's this for', she said, 'I want to make the cake'.

MD What about the pregnancy, when you were pregnant with her?

M2 It was a very heavy pregnancy. Really hard. But it doesn't matter how hard it was, she's my daughter and I love her, just the same as if it was as easy as could be (is agitated).

MD Oh, I know, I know...

M2 I mean, why does she say that?

MD I don't think it's meant to be a criticism of women who have a hard birth. I think she's just saying it's important to try to give women as easy a birth as possible.

M2 Maybe, for midwives, but it's not true. With this daughter (she was just talking about) and my last (born 2000), the pregnancy was really hard and the birth too, but the bringing up was easy. You know I've really nice children. My last one, (if) I put her into bed at eight o'clock in the evening, she will wake up at eight o'clock the next morning. I don't know why, twelve women who've looked after them say the same, they are just good children. It's not me, I don't think. The first one, she gave me a hard time - she woke up six (or) seven times a night,

MD These are your children born in Morocco?

M2 No, the ones I had here. The first was big, really tubby and demanding, you know? But the other, totally different. The ones I had in Morocco, were fine, but the first one here (was) difficult. She wake in the night many times, she cried a lot, this one (the youngest), never. Even when she want me to change a nappy or she want to eat she just went (sound like a goat braying) (both laugh). But, now...now she has a big mouth (both laugh).

MD She doesn't look like it.

M2 No, but if she wants something, she just goes to take it. I don't know, because some women, they say, 'that child, that child, can't make friends with the others'. But between the last two children, I've done nothing different. I mean they should be the same kids.

MD Do you mean, they mean the same to you?

M2 No, I mean I've done nothing different. But they do mean the same to me, although I worry more about this one. The fact that the other is more easy to bring up, that's nothing to do with the pregnancy or the birth. Because some women, they say about their kids, that child, (is) loves me too much and that child (another) cares about me. I wont sometimes I see (look) to think (decide) who likes me too much, but I can't chose between them. They love me all the same.

MD Is part of that the way that they behave though? I mean if you had a child who didn't behave in a way that you agreed with at all, with you think that they loved you less?

M2 I don't think any child is born and hates their mother, or has this lack...But sometimes you can get children who...their behaviour, it's almost like they don't chose it. They're just difficult.

MD OK, we'll talk about this later, when we talk about your first pregnancy...OK, erm...This is also your first pregnancy (laughs). When you were first pregnant, when you first knew, if you can remember back..?

M2 yes, I remember everything (claps hands and laughs, both laugh)

MD ha, good. What did you want to know.

M2 I was fifteen when I knew I was pregnant. All I wanted at the time was to be a mother. That was it.

MD Was there anything you wanted to know to prepare you for being a mother? or were you already prepared?

M2 No, no. Not prepared, I knew I was going to be pregnant, I was getting the clothes prepared, all the towels and the special clothes for just after (the birth). But I'm not one of these people who go all out to get things prepared. I was a young child myself, I didn't know what to do exactly. I had her when I was going on for sixteen years and so when I am pregnant, when I'm going on for the seventh month, I went to my mum's house, I stayed there till I had the baby. She did everything for me, she prepared everything.

MD But you were very pregnant by then?

M2 I went to my mum's house, and she did everything. I don't know nothing - I still played (MD laughs).

MD You still played with your big bump?

M2 Yes, I was running with my sisters, my younger sisters. Believe me, I ran like a man. Sometimes, my mum would say, 'don't run'. But I would run with my sisters.

MD because you were so young?

M2 I was too young, yes. I was a mother at sixteen years. I was pregnant when I was fifteen, I had her when I was going on for sixteen years. She's like my sister now.

MD But when you had your baby then, was it a shock? The responsibility of having your little baby?

M2 yeah, but. Look, having your baby in Morocco is not like here. You have to go outside, you have to do the shopping, you have to do that. That time (in Morocco) it's the man who does everything outside, you are just sitting down, cooking, a lot of time for the child. Nothing else.

MD But then you've got to think of the child's future haven't you? I mean...

M2 Eh...no. Not really. My husband was double my age - which sounds worse than it is because he was only 30. But he knew a lot and I didn't think about the future. I trusted him to do that, what would happen. You don't, when you're that young and you know nothing. To be honest, you don't need to so much, you can predict things, they turn our as you imagine. Your kids don't have the opportunity to get involved in drink or drugs and that, so you think they will be like you. I don't know, now maybe it's better because I think more, but that's because I have to - and because I'm older too, but mostly, because you have to make decisions her, and in Morocco you don't because there is no choice. You're Muslim, you get married, you bring up your kids and you know, unless something really bad happens, it stays the same.

MD Do you miss that?

M2 yes, but I can't change anything. I was a child myself when I had my first one. I don't regret that and...no I can't regret things I've done because it's my life, it's meant to be like this and you can't pick and chose. I'm different from what I was in Morocco, I've had experiences I'd never imagined I'd go through, but you can't go back. You said about the future, but in Morocco, it's just about having children and making sure they live. They survive, it's a hard life. Don't think I'm crying for it. For my first child, I didn't even think about her going to school. When she went, maybe because I had more time, but then I started to think about how you're going to raise them, how they're going to be. But when he's (the child in general - she has only girls) a little baby, you don't think about that...

MD Was that the same with the babies you had here - I mean thinking about their health first?

M2 The same thing...yeah. I couldn't get used to the fact that it's not common for children to be sick, so yes, I would think about their health. I suppose I'm a practical person, and I'm not that concerned about my kids being very, very polite or very holy. So long as they're respectable.

MD What about when you were pregnant - maybe not with your first one - but after, with the ones you had here; did you want to know about risks to the child or how you expected the birth to be? Were you thinking about that when you were pregnant, say early in your pregnancy?

M2 On the day I went to do the tests...the doctor said, 'you have to do the tests,' he wanted to do it. I said no. They wanted to do an injection to find out if the child was normal or if he was damaged. it was because I was above a certain age, having a child. And he said to me, because I said no, 'if the child is damaged, what will you do?' And I said, 'I'll look after it, don't worry'. Then he said, 'I want to do it because maybe the child is coming before (premature)'. I said 'thank you, but if it's coming, it's coming'. Because that's my faith, and because I didn't believe it was for that.

MD And he was OK about you refusing?

M2 Oh, yeah, he was really fine (seems surprised by question). Now my daughter is really fast, she could read before all the others.

MD You must be so pleased (laughs). So you've got three yes?

M2 Yes

MD And the two younger ones, that were born here, they're quite close together?

M2 yes, that's right. One is nearly 3 and the other one nearly 2. Between S*** and F***, twenty four years.

MD What a gap! Why did you wait that long..?

M2 No man (both laugh, M2 claps hands). You know why? The first two, their father in Morocco. When the second one was nearly two, her dad died. I stayed a bit then I married when I came here. So my last two, their father is Jamaican, not Moroccan.

MD OK, I see. So with your two younger ones, when you were, say seven, eight months pregnant, what did you want to know then, now bearing in mind that you'd already had your other babies. But did you want to know maybe about the kind of delivery you'd have , or who would be with you, or what to do if it wasn't straightforward.

M2 I was in the hospital for the check ups, but I've always though, whatever is meant to be is meant to be, it's God's will. I knew in myself, when I was pregnant, that I was well. The time when the pain came, three hours, four hours maybe five, I didn't know (what was happening). Do you know what I mean, nobody knows (how birth will be).

MD But what about the kind of delivery you'd have? I mean did you want to be lying on your back or sitting up or...?

M2 They didn't ask me and I just lay down...

MD Was this the same for the first two?

M2 No, for them I had to stay like this (squats).

MD And what did you prefer?

M2 Well, giving birth in Morocco is much easier. You know why, in Morocco, the lady she have to stay like that, to have her baby like this, all the power is pushing down. Like here you have to lie like this and here someone is pushing but they're pushing against the bed.

MD In Morocco, did you have any pain relief?

M2 Ha, don't be silly, little one (laughs). No one has pain relief! For my second baby here, they gave me an injection in my thigh because I was in labour for a long, long time.

MD How long?

M2 Two days.

MD Hamdou'illah (thanks to God - i.e. that it's OK)

M2 Well, yes. You know normally I can't take pain at all, like yesterday I had a headache, oh I thought it was the end of the world. But it was them who told me I was going to have pain relief, I didn't ask for it. I mean I didn't mind - whatever (could) help me at that time, I wanted it. I mean I was in so much pain I was asking for a Cesarean. But the second one, I had really bad pain but she was born here, with no pain relief.

MD Were you pleased you didn't have pain relief?

M2 The priority for me is that, when you're giving birth, it's whatever helps make it easier. I would have said yes to anything that makes it come more easily.

MD But for you or for the baby?

M2 For the two. The baby need (sic) me and I need (sic) the baby.

MD When you were first pregnant with your first child - what information did they give you? For example, you were living with your husband -did your mother-in-law tell you anything?

M2 I was young, I didn't know anything. I didn't know anything - I nearly had the birth playing with my brothers.

MD Did your mother tell you anything before you were married?

M2 Yeas, I mean we talked about married life - about the family. But for my mum, stopping having babies - birth control is haram (prohibited), if you like.

MD Oh yes, sure. It's not that that I was thinking of but more, what it would be like to be a mother?

M2 Hmm...when I got married, I went away to another city. So I didn't actually see my mum until I was pregnant for five months. And eh...life is changing in Morocco too, people move like they didn't before. And my husband had moved for work. Even my mother-in-law...she lived in one place and we would be travelling far away. When I got...when the time came. You know, can you imagine, my first period was when I got married and after that (laughs) that was it. I had one period and then gave birth, and it didn't go back to normal for nearly three years. But it was really strange to be pregnant straight away and then not to see my mum for so long. She came, my mum and his mum, to visit us to another city, where we were actually living. She knew I was pregnant, she knew but actually.

MD So you knew by then?

M2 yes, but I didn't know I was pregnant for two months. But he knew I was pregnant (the husband). He told me.

MD Had he been married before?

M2 yes, he'd been married before yes, twice. he said to me, 'you are pregnant', because he saw me vomiting and things like that. Then his brother came to visit and he said too, 'she's pregnant'. It wasn't a question of how did I feel. I didn't know I was pregnant and someone told me, I was nearly four months when his brother came, and he saw me, I was not well, and my husband said 'maybe she's pregnant', and he said, 'yes, she is'.

MD And that was OK, you were happy with that?

M2 Yes, because I was married there was no problem. A marriage like that is for the children and he really wanted kids as well.

MD For your second two, the two that you had here, when you were coming up to labour, what was the information that was given to you then? Because you'd had your first two, so you knew, roughly, what to expect, but what did people tell you then? Do you remember?

M2 I had the sisters and the nurses come in to monitor me, to see where the head was lying. I used to go every month - -it was important, because I was quite old by then. Then it would be the doctor who would tell me things. They were monitoring me quite closely because the gap was seventeen years. This is why they were checking so much. I thought the doctor was very good. All the time, he was very patient. He would check the baby's heart and my heart and the blood and everything.

MD So you were happy with that?

M2 Yes

MD And when you were thinking when you were going into labour with your second two, were you thinking what the doctor was telling you or what had happened to you before. How did you prepare yourself in your mind for what was going to happen?

M2 I knew that already, I listened to what the doctor told me -it wasn't much, because it was OK. I knew I'd had had the pain before, I knew I'd had the babies before.

MD (laughs) OK...

M2 I do know people who get very nervous about giving birth. You know, I wait my time and that's it. I slept in the hospital for two days or three days when I was pregnant for eight months with this one, the last one, because the baby was already coming down, pushing down before her time. I had to go to the hospital and sit there, and then the doctor said, 'maybe the baby's coming before her time'. After a few days I said I wanted to go home because I'd left the other one with her dad. And then he let me out, but he said to me, 'don't hover, don't take (carry) something heavy'. But when I came back to the hospital (at term) it was OK. But my stomach is like this -(-hanging low). All the time when I was having children my husband ***, would say, 'I wish you'd stop having children', and when the baby was born, he kept on saying, 'have another one'. And I said 'no' (laughs). Because I never, ever sit down with my feet like this. I couldn't see them...!

MD Was she a big baby?

M2 Nine pounds - something like that.

MD Oh that is big, she's not big now.

M2 No, she's slender. You know already, she's saying ,' I don't want to eat that, I'll get fat'.

MD But she's so young, do you think that's OK?

M2 Well, she's not starving and if she wants to be pretty now, then that's good. For a girl, it's always good to think about how you look.

MD When you're in labour, say there is some decision to make, for example, if you're going to have monitoring or not, who do you think should make the decision? Should it be you or the doctor? Should it be just the doctor, or just you, or both?

M2 To be honest, there was never a situation I could compare it to. All the time, they would say to me, 'the baby is alright, he's growing well. he's OK'...I suppose if there was a risk, the last word should be with him, the doctor.

MD So in an emergency?

M2 In an emergency, it has to be the doctor, because he know what is going on. I can't know. The doctor does know it, that's his job and if there is a risk, I'm not going to take the responsibility from him.

MD After the baby's born, you've got your baby, say, your second two babies. You're lying in your hospital bed and everything is fine. Say they want you to breast feed, who should make the decision about when you start - or if you start at all? is that your decision or should the nurse make it for you?

M2 It depends. For the last one, I was so tired and exhausted - I had to ask the midwife to give her a bottle. So she gave it to her. usually...

MD But that was your decision?

M2 that's right. I'm tired, I said, 'can you please give her some milk. I really can't'.

MD Was that OK?

M2 yes, she came to me, she said, 'do you want to feed the baby?'. I said 'no, just take her and feed her'.

MD And what did she say?

M2 She said yes, she was very kind. She took her, she fed her.

MD OK, erm. I'm going to read you what a midwife said to me because it's about women looking for information and how midwives think about it (reads story 2). Do you think looking for information is a duty?

M2 No. Really, that's not what I think. I mean, looking after your kids is a duty - but it's natural. Information, well I trust what will be will be. It's good to know things, but to know too much, that's just to try and guess what will happen, that's not my religion. It's very English I think.

MD Do you think so?

M2 yes, because she thinks if she knows things, everything will be smooth.

MD I think it's interesting because she says 'duty'. That's a strong word, a lot of the woman I talk to talk about duty, the Arab women, but I was interested that it was a midwife - I mean an English midwife.

M2 The ladies who talk about having kids like that, they don't come from the countryside. They're the ones with nice houses and I think they are close, in their attitude to English women because they always want to change things. I mean I have a lot of respect for them as Muslims, but it's not right to try to know too much. You can't know. You might lose your child after reading all these books.

MD So it should be the midwives who give you the information?

M2 The information you need, yes. But not all the other things.

MD What other things?

M2 Things that might not happen, like the baby in the wrong position. If it happens, they know what to do, not me. What is the point o me (my) hurting (worrying) and the baby getting weak because of something that has only happened to some other women? I have to protect me (myself) and him (the baby). So I don't agree with your lady.

MD Ok, I'm going to skip a question because we've already talked about that....Ah, this is what a Yemeni woman told me about using the information she got by talking to her friends. I thought this was a good example (reads story 3). This woman, she's saying about the stories that other woman were telling her, like 'oh, my birth was like this..' and 'the pain was like this...' So she thinks that this kind of story is information that she uses and she thinks of it in the same way that she would think about information from the doctor. So I was wondering, what kind of information - stories and from the doctors, what helped you, understand what was happening in your labour?

M2 I don't know. This isn't how I'd think about it.

MD I mean during the birth, not before.

M2 I know but I try not to think about it. I suppose I know because of my mother: because I saw her give birth twice.

MD So when you first had your babies, you had seen it?

M2 No, to be honest, I didn't see all the birth, but I was there, in the house, when my mum gave birth to two of my sisters. I remember how my mum copes with it. She cut the cord herself and she tied it herself. Then she and one of my sisters washed the baby. She got the water hot for her. I saw her tie herself up too.

MD What do you mean 'tie herself up'?

M2 You know, 'pull yourself together', you would say here.

MD So you don't mean actually?

M2 Oh I do, I mean, what you do is you tie a cloth really tight around your middle, for support and also to make the extra weight go away quicker.

MD But what kind of things are they - are they wide?

M2 No. They don't have to be. Something like a scarf is big enough.

MD So it's like a sash. Like this (ties scarf around hips) (both laugh)

M2 Well, no that look as if you're going to go dancing like this (shakes hips). It's ties like this (around MD's waist). Are you going to dance for us?

MD No, you're going to dance for me (both laugh)...Anyway, explain to me again about the belt...?

M2 Eh...Your insides are very lose when you give birth, and what you need to do is protect these. Women often catch a cold, if the wind gets up you. So we wear the belt if you like to protect

because it can be a hard time for a woman. To hold things together. A woman might still be bleeding and in a lot of pain. So she needs to eat something hot as well. We eat peppers - black peppers, and the eggs or spice. It cleans you and warms you up. They say as well, it gets the milk going. It's a herb for heat so it heats up the insides, so you can fight against the cold. Eggs are also good for the milk, that's what they say. All the time I remember when I was young, my mum when she had her babies, some neighbours or my sister would make it for her every day.

MD what the eggs?

M2 Everything together -the herb and the eggs. She would eat them for seven days.

MD Why seven days?

M2 After that, people believe the wound has got better. You can get up then and it's not dangerous because it's closed a bit. Chicken as well is good - chicken with sauce. It's delicious, but you need the country chicken - a strong one.

MD One that's been outside? You mean - not in a factory?

M2 yes, the rich one, because you need the good meat. Cooked with fat and some sauce - and pancakes. Everything for the energy. So you make the pancake, you cut it small, small (strips) and you put the sauce in and chicken at the top. It's good for the lady. the pancake gives her milk and give the lady riches (nutrition), or something like that, and the centre, the chicken and source and that is good for recovering.

MD So you did this for yourself and your mother...?

M2 Before I went to the hospital, I make everything, and I left it. I said to my daughter...I made the pancake. I cut it small like this and I said to my daughter, 'When I have the baby, you have to take that and that and bring it to the hospital'. And she did that.

M1 (has walked in) is it pancake?

M2 Yes, it's flat with milk. It's not just the same, but like flat bread with milk.

M1 You might get to see them today - someone is bringing them.

MD Oh, that sounds really good....But erm...you'd seen or you'd heard your mother giving birth..?

M2 I heard her, shouting so I knew she was in pain. She was on her own.

MD On her own?

M2 In the room.

MD Oh, I see. But seeing this pain, did it make you feel afraid at all?

M2 I remember I cried and my sister carried me on her back to take my mind off it. You never carry like that, it's just for babies really, so it was special. To make me less afraid, but I still cried (M1 laughs).

MD But when you were thinking, 'this is going to happen to me'...

M2 I never thought about it like that...I mean not at the time. When I was pregnant and far away, yeah. I thought about that and there was no other woman to tell me how it was – how it ends really because you just see that picture.

MD Never? OK....What do you think makes a woman a good mother?

M2 You need for her head to be right and her thinking to be right. When you're head's right and your mind's OK, you know how to look after your health as well.

MD But as a good mother...how does your head have to be to be a good mother?

M2 You have to clear about what you need to do - for your child. No drugs, no smoking, eating right and thinking right, it's a big responsibility you have for your kids. if they're going to grow up nicely, they can't see you smoking and, and, and what future for that child if they think you're weak? A child need to think you're so strong - -to have confidence. For my first child, I was looking...I wasn't doing anything apart from looking after this little thing. the first thing in the morning to feed her, and after to bath her, to change her clothes, to wean her, when she can't sleep I have to do something and when she wake again, I had to do to her. All the time. I didn't even go out of the door, my husband fetched everything.

MD Did it change you?

M2 Of course, yes, it made me grow up. At fifteen, I was, like I am now....I was a woman, suddenly with a baby and I needed my husband over night, to help me. it changes that too.

MD You mean your relationship?

M2 Yes, before, you can be more free, after you need him for the practical things. Before you give birth you do what you like. You take a walk, you talk to your friends, you might even have men friends. You a free spirit, but after, then you really realise you belong to your child to your husband. I mean, to be honest, I had some quite close friendships with men just after I was married but when the children came, that stopped. Not just because of the lack of time, but you think differently. You have your children there (indicated front of head).

MD So then all your emotional life is for your child?

M2 yes

MD But you still have friends - close friends?

M2 yes, but they are women (M1, who has walked in, laughs).

M1 Are you going to tell her about that? oh, you have no shame (laughs)

M2 Hmm, I have some very close friendships with women, I suppose, but they understand the children come first. All the women I know, and the ones I've been close to, they have children. That's part of the bond. You know it's normal. In Morocco, you might not love your husband.

MD Of course, and he might have another wife?

M2 (laughs) What better way to make peace with her.

MD I'd never thought about it like that.

M2 You don't think like an Arab (laughs).

MD No, but I'm not likely to have a husband with two wives (laughs)

M1 (Still there) is that true? Your man's Arab isn't he?

MD No, no, I keep telling you, he speaks Arabic, but he's French, really he is.

M1 Oh, well if you say so.

MD Why do none of you believe me?

M1 It just doesn't seem likely, sweetheart. This work you do and him speaking such good Arabic.

M2 She thinks you're preparing for getting married...

MD No, no (covers head with hands)

M1 But you have to come back to see us (laughs)

MD Oh no. You're frightening me now (laughs). What have I started? Right...you were saying about how you think differently once the baby is born? (M1 leaves)

M2 When you give birth, the pain is...it's too strong... like you are just a little baby compared to the pain – you can't do anything – like when your baby is born. It gives you the feeling that it is a part of you you're looking at and you have to think for that part of you. You don't want even the bad air to touch the child. I know how much I look after my children? I brought up two, alone. Just one, when she was born, my husband, he leave me in hospital.

MD You poor thing...

M2 You know, sweetheart, I'll tell you the story, but you will break the tape afterwards?

MD No one will know it's you. But if it makes you feel better, I'll wipe out the tape afterwards.

M2 Good. Really I don't care, what happened has happened (is agitated). When I had my second one, my husband, he came to me, well actually, he stayed with me after I had the child...

MD He was with you?

M2 he was with me when I had the child and then he left. When he came back the next day, he said to me, 'why is it a girl, why it can't be boy?' I said, 'it's not for me (to decide), it's for God'. He said, 'I want a boy. How can I live with three women (laughs). I said, 'listen, it's something coming from Allah, from God, it's not for me (to complain).

MD Is he Muslim too?

M2 He is a donkey Muslim (M1 has returned and laughs). Ok, everyone who is Muslim, is Muslim, but he is no good. Islam is too expensive...

MD Is too..?

M2 Islam is something difficult to look after your religion, it's very, very difficult. To abide by it's every rules and even the basics for some are hard. To be a good Muslim, Islam is very difficult, to look after my kids. my oldest is coming up to fourteen. You know that time I lived in Hackney, yes? You know my solicitor, she went to the H** hospital. After she moved (me) to Dalston. I had a problem, when I had the baby, the social worker she gave me (because the husband) when he left me, he changed the locks, he put my clothes in the bin (is angry). It was a big story, it's too much - a sob story, you know what I mean? (cries, pause)

Anyway...Some people they said to me, why do you see him? I said, 'I'm married to him'. Another lady, she said to me, 'you have no sugar, you have no toothbrush', But what happened to us, if God is willing....(it's God's will). He left me in hospital, people were listening and he was swearing, and that in hospital, in H*** hospital, it's a big hospital. The sister, she came to me, she said ,'do you need some help?' I said, 'no, because I didn't want to break my marriage (by getting other people involved). And after...

MD Was it just swearing? Or was it...?

M2 Everything, everything, he was threatening to hurt me, because I didn't have a son. The social worker, she came to me, from the hospital, she said 'you need help?', I said 'no'. And at that time my English was really bad, I didn't speak good English, but there was a lady who worked in the hospital from Morocco, the social worker, she bring the lady to me, she said, 'if you want some help I can give you in hospital, here. Outside, you will have to find another social worker to help you with him (husband). Anyway, before, I could make my decision, he make the phone call to the nursing hospital, he said ,' tell my wife to go anywhere she wants'. I don't have my jacket, I have only hospital clothes, I bring some make-up with me, yeah (laughs).

MD So you were prepared? (both laugh)

M2 But even my shoes I didn't have, only slippers. When I was, in hospital, he took everything. I told them, 'could you get me a phone, I want to talk to him', so she got me the phone and I talked to him, I said, 'I want my jacket', he said, 'no, you'll have nothing from me'. I said, 'how can I go out without a jacket'. The next day, he brought the jacket. I said, 'what's going on?'. He said, ' No, I can't live with you'. And he took the first one (first child) with him. My daughter, the big one (from the first marriage in Morocco), he just told her to go. She just came and he asked her to go! She

came two weeks or three weeks before I had the baby. I called one lady from Egypt, I knew her telephone number. I told her what happened can you please come. She came with her husband, an Englishman and she took my daughters to her home. And the social worker came, she been to the solicitor because he changed the lock. When my daughter went to the house, she couldn't get in. So the staff at the hospital, they helped. I never went outside the hospital, not to buy nappies or clothes for the baby. The social worker, she took me from the hospital to the court. I left the baby in the hospital. They said the baby couldn't come to court. At that time the judge, he made a judgement against my husband and he said to him, 'you have to leave', that day (was) Tuesday. next day, Wednesday, he said, you have to leave. Next day, he came back to the court, with his solicitor and the judge he said to him, 'Sorry, you can't come here, you have to leave (your house) '.

MD You had to leave?

M2 No, he had to leave. He sat down and he said, 'you have to leave because the lady, she has to be in the house'.

MD OK.

M2 The house was all ready. I moved there where I was seven months. I made the curtains, I made everything. We needed the sofa covered and I even made that. He took all the cushion covers, he pulled everything down. I remember in D** and the park behind, the big park in H***, the other side people talking, (with) no curtains, nothing. I'm still bleeding. I'd just come from the hospital. One day I asked my neighbour if she could find something - not curtains - just sheets and we covered the windows. And I had to live there with two babies, he take one of them. When he changed the lock, he took one of them.

MD And she was really young?

M2 One year. yes, because that day when she (was) born, one year- twelve month only - same day. That was a good story, actually (both laugh). It was really sad, actually.

MD So now you are just with your two daughters, yes?

M2 yeah, because when I went to the court, the judge said to him, you leave and you have to give the child to the mother. The first day, when I went to the court, the judge he gave me the police to go with me to get the baby. When I reached the baby, he hid the baby from the police. he put her in a pile of clothes and he said, 'I don't have the baby here'. I heard the baby moving, but I didn't know where. She was under the clothes, but if it wasn't for a small hole in the pile, well she has that to thank (that she survived). But we went back and we got her. In D** it wasn't easy, we just had one small kitchen and with two babies, I had to go downstairs to cook, but I had nothing to cook with. So I asked the woman (proprietor) and she gave me a couple of dishes, and one kitchen towel.

And in the room, just between the bed and the cupboard, nothing. And I asked if I could cook in the cupboard like that, because there was a sink in it.

M1 (has been listening) When was this?

M2 2000 yeah, 2000.

M1 And she said yes?

M2 No, no, she said 'no'.

M1 Hmm. (interruption).

M2 So I stopped breast feeding the baby after the hospital, because I was really tired out. Before I tried with different homemade biscuits to make myself strong. But I had to go from hospital to the court and I don't find nothing, no shoes, not even a scarf. Everything (was missing). I mean for breast feeding they say, that if you don't do it, your kids will have a more distant relationship, but she (the youngest) is the closest to me. You know sometimes, at midnight, for a long time I'm suffering from a sinus problem, yeah? Sometimes at midnight, I'm coughing and *** will come and bring the water, 'mum, are you alright?'... Yeah. yeah.

MD Do you think that she is closer to you because you suffered?

M2 yeah, you know sometimes I say to her and her big sister, when I'm joking and stuff like that, I say, 'I'm going to Morocco, just for a few weeks, she says, 'No, I'm with you, believe me. I can't sleep in the house if you are not in it.' I don't think it is the struggle 'though. It's just the way it is. She wont stay with her dad, just with me.

MD Would you tell people this story? I mean say someone is having a hard time, would you tell them, 'this happened to me, and look at my family now'?

M2 Yeah, yeah, every time. They can take that story, it's for them. It's not my life any more (laughs). You know from that time to this, he still is not married yet. When he goes to the mosque and he wants to get married, some woman, she says, 'oh, he married this lady, no', because that story is very strong to hear, 'that lady, no...' 'If he left this lady, no,no,no,no'. 'If you're married before to this lady, no, no, no, no.'

MD Do you think, because women often tell stories about being pregnant and giving birth, why do you think they say these stories to each other? Is it yaani, to prepare themselves or to warn, each other..?

M2 I don't know. I see lots of women talking about their experiences, but I never talk about giving birth and having children.

MD Do you think, that's because you had such a hard time?

M2 You know really, my faith is still very strong. I like to hear my mum, she talks a lot, about her stories, but from other women, I don't hear them so much.

MD Do you think it's - because you say your faith is strong - do you think if you've got strong faith, you don't need to talk with other women? 'What will be, will be?'

M2 yeah, this is true. I believe that, yeah. But the only time I heard a story about giving birth, was from my mother who sat me down and ate peppers - hot peppers. She cooked the conscious and she ate it with hot peppers, and before she stand up, the blood is coming down, the baby is lost. She lost the baby that time.

MD Oh, OK...

M2 I used to love hot food especially peppers. But after (I) didn't eat them so much.

MD So she ate the hot peppers afterwards?

M2 No, she was eating them and while she was eating them, she lost the baby. But when you are pregnant with a baby, my mum, she was with me when I had my first one. She said, 'push, push' I said 'what's this push?' (why do I need to) (laughs). I feel I want to go to the toilet. I said 'take me to the toilet'. She took me there, I said 'no, take me back'. I said, 'now I want to go to the toilet again' (both laugh). So she said, 'my daughter, you don't really want to go to the toilet.' And then I said again 'take me to the toilet' and I just sat down like this (squats). And I said, 'oh no, not here, take me back' and one time, she said, 'why can't you do it here'? I said 'I can't, take me back' (both laugh). Ah, because when the baby is pushed down, well you really want to empty your bowels. It's true. Ha, you'll see.

MD Thanks (both laugh).